Neutral Citation Number: **[2026] EWHC 2294 (KB)**

Case No: KB-2023-001663

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 4 September 2026

Before:

ANDREW KINNIER K.C.
(Sitting as a Deputy Judge of the High Court)

Between:

JBX
(Suing by DBX, his Mother and Litigation Friend)

Claimant

- and –

FRIMLEY HEALTH NHS FOUNDATION TRUST

Defendant

David Tyack K.C. and Nigel Spencer Ley (instructed by **Lime Solicitors**) for the **Claimant**
Claire Toogood K.C. (instructed by **Capsticks LLP**) for the **Defendant**

Hearing dates: 6-8 and 11-15 May 2026

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Approved Judgment

This judgment was handed down remotely on 4 September 2026 at 4 p.m. by circulation to the parties or their representatives by email and released to the National Archives.

ANDREW KINNIER K.C. sitting as a Deputy Judge of the High Court:

Introduction

1. This judgment is concerned with the assessment of damages in the claim brought by JBX ("**the Claimant**"), who sues by his mother and litigation friend, against Frimley Health NHS Foundation Trust ("**the Trust**") in relation to its admitted clinical negligence. Two heads of loss now fall to be decided: the claims for future care and accommodation and the Claimant's lost years of income.

2. This judgment is in eight Parts:

   (a) Part 1 (paras. 3-9) sets out the relevant background;
   (b) Part 2 (paras. 10-16) summarises the procedural history;
   (c) Part 3 (paras. 17-22) addresses various preliminary matters such as disclosure and privilege;
   (d) Part 4 (paras. 23-63) reviews the factual evidence;
   (e) Part 5 (paras. 64-122) summarises the expert evidence;
   (f) Part 6 (paras. 123-125) sets out the parties' agreement on quantum;
   (g) Part 7 (paras. 126-166) considers future care and accommodation; and
   (h) Part 8 (paras. 167-206) deals with the lost years claim.

PART 1 – the relevant background

The Claimant

3. The Claimant was born on 2 June 2009: he is now 17 years old. He started to suffer from asthma in early childhood for which he received regular treatment. The Claimant's condition deteriorated in the latter half of 2017 when he was regularly admitted to hospital for observation, review or emergency treatment. In December 2017, he was diagnosed with poorly controlled asthma.

The Claimant's treatment on 4 January 2018

4. In the early hours of 4 January 2018, the Claimant's mother brought him to Frimley Park Hospital near Camberley ("**the hospital**"). He presented with shortness of breath; low oxygen saturation; elevated respiratory rate and a very elevated pulse. Following assessment, the Claimant was discharged at 2 p.m. and he went to stay at his father's home near Cambridge.

5. At about 8.30 p.m. on 5 January 2018, the Claimant's condition deteriorated markedly. He stopped breathing and suffered a cardiac arrest and as a result a hypoxic brain injury. The Claimant was initially taken to the Emergency Unit at Hinchingbrooke Hospital where he was intubated but on 6 January 2018 he was transferred by air ambulance to Addenbrooke's Hospital in Cambridge. On 11 January 2018, an MRI scan confirmed he had suffered a significant brain injury. In due course, the Claimant was transferred back to the hospital and later to Southampton General Hospital. In his first weeks at Southampton, the Claimant was once again admitted to intensive care but by May 2018 his condition had stabilised sufficiently to allow him to be discharged.

The Claimant's present care and accommodation

6. Since May 2018 the Claimant has lived at Chestnut House, a part of Tadworth Court, a residential rehabilitation centre for severely disabled children near Epsom. Although only a short-term stay was initially anticipated, it soon became clear that his condition was serious and his care needs were such that it would be impossible for him to be looked after solely by family and friends. The Claimant will stay at Tadworth Court until June 2028 when he reaches his 19th birthday.

The Claimant's present condition

7. The consequences of the Claimant's hypoxic brain injury were catastrophic and he is now profoundly disabled. The complexity of his condition is largely agreed and the weight of the expert evidence is that he has:

(a) a prolonged disorder of consciousness which is classified as a minimally conscious state. He is unable to communicate or make decisions.

(b) a profound four-limb motor disorder with mixed spasticity and dystonia. His posture is maintained using specialist seating, spinal braces and structured positioning systems. His carers move him throughout the day and night.

(c) little or no use of his hands and fixed flexion contractures of both elbows, wrists and knees.

(d) been assessed, using the Gross Motor Function Classification System, as "grade 5 equivalent", the most severe functional limitation of self-initiated movement. The Claimant is wheelchair-bound.

(e) epileptic seizures on most days for which he sometimes requires rescue medication. His symptoms present in various ways but the episodes typically last for 30 seconds or so. There is a significant prospect that the Claimant's seizures will never be controlled and his epilepsy is unlikely to resolve spontaneously. The management of the seizures is subject to a protocol.

(f) severe dystonia which causes him to suffer sometimes severely painful and prolonged muscle spasms and cramps as well as significant distress. Episodes occur daily and their management is also subject to a protocol. Symptoms can be triggered by various events including noise and proximity to other residents who can be loudly vocal. In response, the Claimant's carers re-position him, provide reassurance and, when needed, medication.

(g) neuromuscular scoliosis which requires the Claimant to wear a brace. He also suffered from progressive subluxation and dislocation of both hips for which he underwent surgery in 2020. He continues to suffer from hip deformity and there is a risk of dislocation.

(h) asthma for which he receives daily medication and whose management is subject to a protocol.

(i) recurrent nasal polyps which increase the number of dystonic episodes.

(j) severe visual impairment which is attributed to a cortical visual impairment. In other words, although there is no structural problem affecting his eyes, his brain cannot process images. The ophthalmological experts agree that it is very unlikely that the Claimant has any significant appreciation of vision at a cortical level. They also agree that the reports of visual response from family and carers may reflect other aspects of sensory function.

(k) frequently disturbed sleep.

8. The Claimant is unable to feed himself. He receives nutrition from a gastro-jejunal tube which has been problematic in the past and is likely to continue to be so. The Claimant experiences retching daily as well as constipation. He is doubly incontinent.

9. The neurological experts broadly agreed the Claimant's life expectancy. Dr Manish Prasad, who is retained by the Claimant, estimated his life expectancy to be 26½ years of age. Dr Shakti Agrawal, who is instructed by the Trust, considered that expectancy lies somewhere between the Claimant's early and mid-twenties. For present purposes, the parties reached a compromise that the Claimant's life expectancy is 25½ years.

PART 2 – the procedural history

Pre-issue

10. On 9 March 2021, a letter of claim was sent to the Trust. It was alleged that on 4 January 2018, the Claimant presented at the hospital with life-threatening asthma and a six-month history of worsening asthma. Two breaches of duty were alleged: a failure to prescribe prednisolone, a steroid medication, at any time when the Claimant was under the hospital's care and the premature decision to discharge him.

11. In its letter of response dated 27 August 2021, the Trust admitted negligence and causation. It was accepted that on 4 January 2018, the Claimant should have been admitted to hospital and prescribed a five-day course of steroids and his treatment fell below a reasonable standard of care following his admission. The Trust also accepted that, but for the admitted breach of duty, the Claimant would not have suffered a cardiac arrest and hypoxic brain injury on 5 January 2018; with appropriate treatment his asthma would have been controlled and in due course he would have led a fully independent adult life.

Post-issue

12. The claim was issued on 28 March 2023. In light of the Trust's pre-issue admission of negligence and causation, on 8 December 2023, judgment was entered for the Claimant and directions made for the assessment of damages. In addition to orders for the exchange of a Schedule of Loss and Damage and a Counter Schedule, the parties had permission to rely upon expert evidence in 10 disciplines: paediatric neurology; care and occupational therapy equipment; paediatric orthopaedics; paediatric neuropsychiatry; physiotherapy; speech and language therapy; assistive technology;

accommodation; ophthalmology and Deputy and Court of Protection costs. The parties also had permission jointly to instruct a gastroenterologist.

The updated Schedule of Loss and Damage, the Counter Schedule and the revised Schedule

13. The two principal heads of loss pleaded in the Claimant's updated Schedule of Loss and Damage (dated 12 March 2026) were the claims for future care and accommodation and the lost years. As to the former, it was said that the Claimant had been advised to move to community-based care in his own property as soon as possible. To that end, a lump sum of £9,556,336 was sought or alternatively periodical payments comprising a lump sum element (£1,411,959) and annual payments of £1,052,245 from December 2027. The capital cost of acquiring a property was alleged to be approximately £1.125M which, after deduction of its reversionary value, the capital sum claimed was £420,075. As to the latter, it was assumed that the Claimant would retire at the age of 70 because the statutory retirement age was likely to have increased by 2079. It was also assumed that the Claimant would spend 50% of his net income (from both earnings and pension) on living expenses. His pre- and post-retirement losses were alleged to be £1,419,190.60 and £486,769 respectively.

14. The Trust's updated Counter Schedule (dated 2 April 2026) foreshadowed the arguments that were advanced at trial on the two contentious heads of loss. As to care, it was submitted that the evidence strongly supported the likelihood that the Claimant would remain in residential care given the complexity of his care needs. The costs of such care were said to be £4,842,972.96 and it was agreed that periodical payments, starting in December 2027, were appropriate for future care. As to the lost years, two principal objections were raised: first, it was appropriate to apply average figures rather than the Claimant's father's earnings which, in any event, were unsupported by the evidence. Secondly, it was not appropriate to apply a discount of only 50% to reflect living expenses. Relying upon comments by Lord Burrows and Lord Stephens in the recent Supreme Court decision in *CCC v. Sheffield Teaching Hospitals NHS Foundation Trust* [2026] UKSC 5, the Trust contended that the discount may be (a) high to reflect the degree of uncertainty involved and (b) rough and ready (but not arbitrary) and caution should be applied against using a simple or conventional discount. The Trust, therefore, argued that a discount of 90% was appropriate given that the Claimant's future career is highly speculative and the likely higher living expenses in the south-east of England. On that basis, £160,345.21 was allowed.

15. On 28 April 2026, the Claimant served a revised Schedule. Although there were some modest changes to the relevant calculations, the revised Schedule did not change the substance of the principal arguments in respect of the two contentious heads of loss.

The trial

16. The trial of quantum was listed for 12 days but the parties were able to narrow the areas of dispute so that the trial lasted nine days and oral expert evidence was confined to the four disciplines of neurology, neuropsychiatry, care and physiotherapy. I am particularly grateful to Mr David Tyack KC and Mr Nigel Spencer Ley, who appeared on behalf of the Claimant, and Ms Claire Toogood KC, who acted for the Trust, for their considerable efforts in allowing the trial to be conducted efficiently and well within the time allowed. As discussed below, late disclosure and a related question of

privilege imposed substantial additional burdens on counsel in addition to the already significant work of conducting a complex assessment of damages. I greatly appreciated their assistance in resolving those matters and the quality of their submissions.

PART 3 – preliminary matters

Anonymity order

17. On the first day of trial, I made an order anonymising the Claimant ("**JBX**"), his mother ("**DBX**") and his father ("**ABX**"). For the reasons given in my *ex tempore* judgment and following the Court of Appeal's guidance in *PMC v. Cwm Taf Morgannwg University Health Board* [2025] EWCA Civ 1126, the order was necessary to protect the Claimant's rights under Art. 8 of the European Convention of Human Rights, to reflect the fact he is a child and the confidential and sensitive nature of his medical history. It struck the appropriate balance between the Claimant's rights and interests and the fundamental demands of open justice by allowing the facts of the case to be reported subject to anonymity.

Disclosure and privilege

18. The Claimant's disclosure has been both substantial and, in parts, lacking. I was told that it encompassed some 40,000 pages of medical notes and other documents. The scale of disclosure was illustrated by the large hard-copy trial bundle and the very large electronic bundle containing the Claimant's medical records. Its problems were demonstrated by the supplemental bundles and the many clips of documents that were needed to be produced during the hearing.

19. Some significant time at trial was spent dealing with the consequences of the late disclosure of the case managers' notes, associated WhatsApp exchanges and whether and, if so, to what extent their substance was privileged. Disclosure-related issues were raised every day and serious concerns about the rigour and adequacy of the disclosure exercise carried out by the Claimant's solicitors soon became clear. In response to my direction for an explanation of the nature and extent of the disclosure search and its deficiencies, Mr Neil Clayton (the Head of Medical Negligence at the Claimant's solicitors) gave a candid account in his letter of 11 May 2026. Following an investigation, Mr Clayton concluded that a full set of Ms Jackson's case manager notes, parts of Ms Waters' contemporaneous management notes (described as "Q notes" in the evidence) and relevant WhatsApp communications should have, but had not, been disclosed. Case manager records from both Ms Jackson and Ms Waters were duly provided.

20. Two further questions arose from Mr Clayton's letter: whether the Claimant's documents should be interrogated further to identify any additional relevant material and whether the nature and extent of the redactions applied to certain WhatsApp exchanges on the ground of privilege were justified.

21. As to the former, from the start of the trial I had been concerned that the additional work and frustration caused by the late disclosure should not obscure the fundamental questions whether the disclosure was material and whether a further search was likely to yield documents that were relevant to the much-narrowed issues before the court.

Having considered the position following Mr Clayton's letter and taken instructions, Ms Toogood confirmed that the Trust had decided not to press the Claimant's solicitors to carry out a fresh search.

22. As to the latter, Ms Toogood raised concerns about the approach adopted by the Claimant's representatives to privilege and the redaction of certain WhatsApp communications between the case managers and DBX. It was submitted that some inconsistencies in redaction suggested that the Claimant's lawyers had taken an unduly broad view of privilege. To resolve matters and by analogy with the approach adopted in *West London Pipeline and Storage Limited v. Total UK Limited* [2008] EWHC 1729 (Comm), the parties agreed that I should inspect the relevant documents to decide whether the redactions were justified. I did so and concluded that, except in one very minor respect, the plea of privilege was properly maintained and the redactions appropriately made.

PART 4 – the factual evidence

Generally

23. Eight witnesses of fact were called by the Claimant and the summary set out below concentrates on those parts of their evidence that were relevant to the future care and accommodation and the lost years claims. The Trust called no factual evidence.

The Claimant's mother

24. The evidence-in-chief of DBX, the Claimant's mother, was contained in three statements dated 6 August 2024, 6 March 2026 and 30 April 2026. Before his injury, the Claimant was doing very well at school: although he was not at the top of the class, neither was he at the bottom. Although he was very attentive to his schoolwork (and particularly enjoyed art), he was more sporty than academic. Before the Claimant's discharge from Southampton to Tadworth Court, the family had considered adapting DBX's home to allow him to return there. The idea was soon dismissed because they realised that the house could not be made suitable for the Claimant. If the Claimant were to stay at home, a new property would have to be purchased.

25. In relation to his care, the Claimant has one-to-one support from a carer 24 hours a day. Two carers support him in all transfers and personal care. He has nurse-led care three to four times a week but there is always at least one registered nurse on shift. Overnight one-to-one care has been recently reinstated because of the increase in seizures which left him distressed, unsettled and highly dystonic. The Claimant is reliant on carers for all aspects of his mobility. Although he has a wheelchair with full lateral and head support, he does not tolerate it for long and so he is moved on his bed at times. The Claimant also requires regular oral care to manage aspirating secretions.

26. The Claimant does not cope well with noise and it triggers his dystonia. If he is surrounded by noise or there is a sudden loud bang, the experience can cause him to suffer a seizure. When the Claimant has a hospital appointment, he is placed on a stretcher in the ambulance as he cannot otherwise tolerate travel. The Claimant is always accompanied by his mother and a carer as two people are needed to look after him and to roll, hoist and bathe him.

27. The Claimant has a height-adjustable bath and a stretcher bath aid allows him to be partly submerged in the water and washed by his carer. He requires full assistance for dressing and undressing. The carers help with all aspects of his grooming apart from nail-cutting which his mother does for him. He requires two carers to help with his pad changes for which he has a height-adjustable shower trolley and table. In the context of his education, DBX said that "he can't do anything. He can't talk and he can't use his fingers. He has to have somebody to do absolutely everything for him." That said, his mother's evidence is that "he understands everything." Indeed, her firm view is that the Claimant knows more than those around him think he does. The Claimant prefers being in his room because he does not like too many people around him. He also does not like loud noises.

28. As to his ability to communicate, the Claimant will attempt to lift his head following a verbal or touch cue and try to activate a button switch which is mounted for his head on the left side or by his chin. When using eye-gaze technology and wearing his glasses, the Claimant can follow consistently unless he is tired or unwell. He can use an iPad using his chin. The Claimant groans or grimaces if he does not like what is happening. The Claimant cannot read or write but he responds positively to audio-books, television and listening to music. His mother would like the Claimant to be able to use the hydrotherapy pool "even twice a week or at the weekend."

29. As to the future, DBX recognised that the Claimant's condition was not going to improve and he would remain dependent on others for all aspects of his care, communication, mobility and transfers. Ideally, DBX would extend her house to allow the Claimant to live with her but she accepted the accommodation expert's view that her home was not suited to meet the Claimant's long-term needs. She did not want him to be "institutionalised forever" and "when he leaves school I do not want him to be neglected in a hospital." For that reason, "my priority is to have [the Claimant] at home with carers and everything that he needs. However, I think a bungalow nearby would be ideal."

30. Her firm preference was for the Claimant to have his own home once he leaves Tadworth Court. That view was partly informed by her experiences of night-time care at Tadworth Court where a limited number of staff and carers would be on duty and required to look after eight children. Because of the various problems that the Claimant had encountered at Tadworth Court, his then case manager recommended and obtained private night-time care. DBX also saw other advantages such as more frequent trips and a timetable of events that suited him especially in relation to hydrotherapy. At Tadworth Court, if another child was making noise, the Claimant could suffer a dystonic episode or have a seizure. The Claimant would be more at ease in his own home: for example, he is shy in front of others when he is eating or doing activities. He would also benefit from the support of family, friends and the broader community. She had visited Bagshot Park but she did not like it: it was on the main road and the age profile of the "incredibly old" residents would not be appropriate for the Claimant.

31. In response to the Trust's suggestion that the reasonable course was for the Claimant to live at Inspire Neurocare ("**Inspire**"), a neuro-rehabilitation centre, DBX had two principal objections: Ms Nicola Waters, the Claimant's present care manager, had told her that the residents were aged over 50 which is far older than the community to which

the Claimant is used. DBX was also concerned that he would deteriorate "massively" and so there would be a commensurate decrease in his mental health and well-being.

32. Cross-examination chiefly concentrated on three topics: determining the extent of the Claimant's present condition; the appropriateness of a home-based setting in the future and whether and, if so, to what extent the Claimant's parents had investigated appropriate neuro-rehabilitation units.

33. There was a general consensus about the nature of the Claimant's condition. DBX agreed that he was in a minimally conscious state. She also agreed that he was unable to communicate his needs verbally and relies on others to interpret his vocalisation, facial expressions and body movement. When distressed, the Claimant would cry and grimace but it was not always possible to identify the trigger. Staff and family members try and work out the cause by a process of elimination. There were times when the Claimant stilled his movements in response to tactile and auditory stimuli. Although it was accepted that the Claimant cannot see, DBX emphasised his ability to track movement. It was agreed that he could hear.

34. When pressed by Ms Toogood, it was clear that when DBX signed her first statement in August 2024, she had not yet decided the best form of accommodation for the Claimant after he left Tadworth Court. However, she now thought that living in his own house with carers and close to his family was the best option. Although DBX accepted that problems could arise in any setting, her substantial reservations about institutional care arose from incidents at Tadworth Court when she thought that care had fallen below what would be reasonably expected. It was not entirely clear whether the clinical risks of the Claimant living in his own house, compared to its psycho-social benefits, had been fully considered by DBX and ABX in light of all the expert evidence.

35. DBX was questioned at length about the extent to which neuro-rehabilitation units near her home had been considered, namely Bagshot Park Neurorehabilitation Centre ("**Bagshot Park**"), Inspire and Holy Cross Hospital in Haslemere ("**Holy Cross**"). It was not clear why DBX's various visits to these units had not been addressed in her three witness statements. It was, however, clear that she did not like Bagshot Park for a range of reasons including its proximity to the road and what she perceived to be the consequential risk to the Claimant's safety. The age of the residents at Inspire was considered a substantial disadvantage. DBX thought Holy Cross was impressive but some distance from her home.

36. At Ms Toogood's request, DBX was recalled to answer a specific question about why she had decided not to continue with the services of Ms Jane Jackson as case manager. In short, the decision was made on her solicitor's advice but DBX could not remember the specific reasons.

The Claimant's father

37. The evidence-in-chief of ABX, the Claimant's father, was set out in his statement of 2 August 2024. ABX's communication with his son was hard because it was one-sided. The Claimant could express when he was unhappy by crying out but the cause of his unhappiness was sometimes difficult to identify. Although the Claimant would turn his head towards a voice, ABX did not know whether he enjoyed his father's visits.

38. As to future care, the principal consideration was the Claimant's move from Tadworth Court. He thought that the stimulation and interaction provided by the staff was very good but it was dependent on the Claimant's health. The Claimant particularly enjoyed the hydrotherapy pool: it was relaxing; it allowed him to get into different positions and to stand upright because of the feeling of weightlessness in the water. ABX thought the Claimant's interests would be best served by living in his own home. Both the Claimant's parents were concerned by "horror stories in care homes and it's just not the same level of care" and "I don't want him to be sitting stagnating in an adult care home." ABX placed a particular premium on the therapeutic value of hydrotherapy and trips.

39. In relation to his earnings potential but for his injury, the Claimant's elder brother had started an apprenticeship at the age of 16 and, at that time, wanted to follow his father, grandfather and great-grandfather into sales in due course. ABX thought it likely that, but for the injury, the Claimant would have pursued a similar employment path to him and gone into sales.

40. In cross-examination, ABX accepted that when he signed his statement in August 2024, the family had not yet decided the best place for the Claimant after Tadworth Court. He emphasised that ensuring his son's quality of life was an important consideration but he accepted that his son's presentation was complex and clinical safety was a "big part" of the decision about the Claimant's future care and accommodation needs. As DBX bore the heavier burden of their son's care and support, ABX tended to defer to her judgment about those needs and so he had not visited any of the identified neuro-rehabilitation units such as Inspire, Bagshot Park or Holy Cross. ABX said that the decision-making about his son's transition from Tadworth Court had been complicated by an absence of clarity from Wokingham Borough Council, the local authority with responsibility for the Claimant. In re-examination, ABX said that, if his son's clinical safety could be assured, he would like him to live at home.

The Claimant's joint financial deputy

41. Mrs Sarah Brack is the Claimant's joint financial deputy with DBX. Mrs Brack's evidence on the Claimant's future care and accommodation needs was dealt with in her second statement of 10 March 2026. Her firm belief was that the Claimant should live in his own home and ideally with other family members. That belief rested on two factors: Mrs Brack's opinion that "living in a loving family environment with a bespoke nurse-led care package would give him the best possible life and ensure that his life opportunities are maximised". The freedom of his own home could not be overstated and, in particular, the value of ready access to hydrotherapy that would not otherwise be easily available to him. Secondly, a home-based setting would avoid or mitigate the difficulties in securing access to elements of the statutory provision at Tadworth Court and retaining certain therapies and equipment on a private basis.

42. The primary challenge in cross-examination was the evidential basis of Mrs Brack's view on future care and accommodation. In her answers, Mrs Brack said that she relied upon the advice of Ms Waters, her general experience as a deputy, her assessment of Tadworth Court and the problems she had encountered there in relation to the provision of care, changes in routine and the Claimant's access to therapies and other treatments. Mrs Brack could not remember whether she had considered the reports of Dr Agrawal

(the Trust's neurological expert) when assessing which accommodation option met the Claimant's reasonable needs. It was also unclear whether she had considered the reports of Dr Prasad, the Claimant's neurological expert, who had not expressed any view on the Claimant's future care and accommodation when Ms Brack's statement was signed.

43. At Ms Toogood's request, Mrs Brack was also recalled to answer questions about why Ms Jackson was replaced by Ms Waters as the Claimant's case manager. In short, Mrs Brack was concerned that although funding was available for the Claimant to receive certain therapies (such as speech therapy), they had not been provided. Mrs Brack also wanted a "fresh pair of eyes" to consider the Claimant's needs and the treatments and therapies he required. There was no suggestion that DBX or Mrs Brack had any personal difficulties with Ms Jackson. Although the Claimant's solicitor had expressed some reservations about aspects of the provision at Tadworth Court, the decision to engage a new case manager was made in the Claimant's best interests and had nothing to do with the litigation. Finally, two letters of instruction were sent to Ms Waters as the new case manager: the first was a general letter to consider the Claimant's immediate needs and the second was a request to consider Inspire as a potential home. Although Mrs Brack could not remember the extent to which it was discussed, a view was taken, on the basis of advice from the case manager and the multi-disciplinary team, that Inspire was not appropriate.

The Claimant's carers

44. Three carers from Chestnut House were called on behalf of the Claimant: Mr Andrew O'Reilly, formerly the house manager and the Claimant's keyworker; Mrs Louise Bower, a child support assistant; and Mrs Samantha Hood, a senior child support assistant and the Claimant's present keyworker.

Andrew O'Reilly

45. Mr O'Reilly's evidence-in-chief was contained in his statement of 5 August 2024. He said that although the Claimant's condition was relatively more stable than when he first came to Tadworth Court, his quality of life was "very poor, he has no formal means of communication and was not able to tell us how he is feeling other than to vocalise that he is in pain." The Claimant was unable to do anything for himself and he required all his care needs to be met. It was obvious when the Claimant was in pain or discomfort because he would vocalise it and show his emotions by his facial expressions. He therefore needed carers who knew him well; could interpret his needs and, when necessary, intervene to support him. He was more comfortable with family and staff members who were well known to him. The Claimant's dystonia was "very severe and complex to manage". He was prescribed medication and a protocol was in place to manage the condition and its consequences. Hydrotherapy relaxed him: "[the Claimant] gets so much out of hydrotherapy … you can tell he just chills out in the pool". Although it was not obvious that the Claimant enjoyed any particular activity, he seemed to like family visits and watching football or his father playing the video game "FIFA". If a journey was expected to be less than 20 or 30 minutes long, the Claimant would usually travel in his wheelchair in one of Tadworth Court's buses. If the journey was expected to take longer, the Claimant would travel on a stretcher to external medical appointments because he was more settled and it was easier to re-position him.

46. The Claimant was one of the highest medicated children on site. Over four pages Mr O'Reilly's statement itemised the Claimant's many medications and supplements. He was "very sensitive to changes in his medication and doses and we don't tend to change anything without seeking external expert advice". Clinical management of six aspects of the Claimant's condition were subject to protocols: bradycardia; dystonia; urinary retention; seizures; asthma and allergies.

47. In cross-examination, Mr O'Reilly confirmed that he had left Tadworth Court in February 2025 after seven or eight years' service. Many of the staff had worked at Tadworth Court for some time although others left sooner because of the challenging nature of the work. He explained that eight members of staff would be on duty at any time supplemented by a "floating" nurse in charge. All manual handling tasks required two staff members. The layout of Chestnut House was favourably contrasted with a hospital ward: "it isn't like a hospital; it's more like a home." Mr O'Reilly said that the structure of the house allowed staff to exchange advice and to work as a team. He agreed that the Claimant had complex needs and emphasised the Claimant's enjoyment of hydrotherapy. Mr O'Reilly agreed that it was useful to have the doctors available to advise the care assistants not least because they had prepared the protocols which guided management of aspects of the Claimant's presentation.

Louise Bower

48. Mrs Bower's evidence-in-chief was set out in her statement of 20 September 2024. She emphasised the importance of a core team to ensure continuity of care for the Claimant. He could be unsettled if he did not feel safe, not listened to or staff were not responding as swiftly as he would have liked. His mother's voice would usually calm him down but if a carer was unable to settle him, it may have been due to not knowing the Claimant's likes and dislikes. Mrs Bower said that the Claimant "absolutely loves" hydrotherapy. It completely relaxed his muscle tone and "mentally and physically it is very beneficial." In relation to the Claimant's dystonia, it was difficult to say how often he experienced symptoms. Sometimes, he could have weeks when the episodes are really bad but there were weeks when "there's nothing at all" and there was no explanation about how or why they happened.

49. Two other points emerged in cross-examination: Mrs Bower had worked at Tadworth Court for about seven years but some staff members had worked there for even longer. Hydrotherapy relaxed the Claimant but sometimes a balance needed to be struck between its benefits and other activities. For example, returning to a noisy environment might disturb the Claimant and so prompt a dystonic event.

Samantha Hood

50. Mrs Hood's evidence-in-chief was contained in two statements dated 5 August 2024 and 12 March 2026. The first addressed the Claimant's daily regime and his condition. She said that most weekends, the Claimant would go on a trip which he enjoyed. The Claimant received hydrotherapy twice weekly to help his dystonia: "he is at his most relaxed in the pool and it really calms him down." Mrs Hood also said that the Claimant was subject to constant monitoring. He had regular feeds during the day throughout which he received gastro-drainage. Mrs Hood could tell when the Claimant was

enjoying something: he would look relaxed and his arms would hang loosely by his side. He could turn his head around and turn towards you if you were talking to him. It was also clear when the Claimant was unhappy: he would grimace and, if his symptoms were not immediately addressed, the Claimant would start to vocalise and cry out which, in turn, would trigger his dystonia. The Claimant would suffer a daily epileptic seizure which would last about 30 seconds. Dystonic episodes would happen a few times each day but they were less frequent than before (especially since his nasal polyps had been treated). The Claimant struggled with new staff-members and so he had never been cared for by agency staff or new staff. As Mrs Hood said " … we all know him and understand that he needs people who know him well caring for him or he will be dystonic all day." Mrs Hood's view was that the Claimant's dystonia was "the main issue and is the reason why he needs so much care." She also considered that the Claimant would benefit from daily swimming sessions and regular outings. It was also important for the Claimant not to become isolated. Mrs Hood echoed DBX's evidence when she said that he thought that the Claimant "is a lot more aware than people may think." She recalled that the Claimant tended to become anxious at the time when the staff handover to the next shift. For example, once he knows who will be with him for the day, the Claimant will settle back to sleep.

51. Mrs Hood's second statement made two principal points: (a) DBX was concerned that those who cared for him knew him well so that they understood what he wanted and could respond sufficiently quickly to avoid a dystonic event and (b) the Claimant enjoyed his own space and the freedom to do what he liked. If he was with other children, participating in shared indoor activities or if there was an activity which he did not want to do, the Claimant could become agitated and then dystonic. He seemed most content in one-to-one situations (especially swimming and music therapy).

52. In cross-examination, Mrs Hood confirmed that she had worked at Tadworth Court for 15 years; the work could be challenging and that some staff struggled with its highly medical nature. In addition to four healthcare assistants, there was also a shift leader. When trips were organised, quite often there would be no nurse or doctor, only healthcare assistants in support. Usually, the Claimant was accompanied by one or two other children on the trips. As to hydrotherapy, Mrs Hood said that it was hard to know whether the Claimant is asleep or simply relaxed. He could, therefore, appear to be asleep while he was in the hydrotherapy pool.

53. In re-examination, Mrs Hood confirmed that the Claimant was currently receiving hydrotherapy three times weekly but that was the most that could be arranged for him by Tadworth Court because other children also needed access to the pool. As to staffing, a nurse may not be on shift but one will be on-site. During the daytime, it was rare to have a nurse on shift because the house-manager was a nurse.

The Claimant's case managers

54. The court heard from Ms Jane Jackson and Ms Nicola Waters, his former and present case managers.

Jane Jackson

55. Ms Jackson's statement (dated 12 September 2024) was her evidence-in-chief. She was appointed the Claimant's case manager in the autumn of 2023. Although her statement was principally concerned with historic matters, two matters should be noted: first, in the past, the Claimant did not receive one-to-one care at night so he was often left alone after 7.30 p.m. and so, if he was distressed, DBX could calm him by talking to him by telephone. The process of securing one-to-one care at night lasted six months between February and July 2024, a delay caused by problems faced by Tadworth Court recruiting staff. Secondly, Ms Jackson summarised the difficulties she had faced securing necessary therapies and treatments for the Claimant (but particularly an extra session of hydrotherapy) at Tadworth Court. She considered that many barriers had been placed in the way of the Claimant receiving treatments etc that he needed; there had been poor and inconsistent communication and the multi-disciplinary team's recommendations had not been implemented. In short, the Claimant "could have made progress, but for the delays caused by Tadworth, this is not in [the Claimant's] best interests."

56. Cross-examination focused on Ms Jackson's view that living in his own home, with carers, was the best option for the Claimant. She had experience of individuals whose needs were as complex as those of the Claimant who lived at home, supported by carers, safely. There would need to be a team leader and a nurse on every shift as well as a "very comprehensive care plan". Although some of the care team would be employed, others would be agency workers. Ms Jackson said that, if a good working relationship were established with the agency and the case manager is proactive, the lesser degree of control over agency workers could be effectively managed. In relation to the decision not to retain her services, Ms Jackson understood that Mrs Brack had been unhappy about the absence of a dietician/nutritionist and certain equipment.

57. In re-examination, Ms Jackson said that, in looking for the right agency to provide care staff, she would examine the rating awarded by the Care Quality Commission ("**the CQC**"); discuss the Claimant's particular needs and satisfy herself that they could service them.

Nicola Waters

58. Ms Waters' statement (dated 10 March 2026) can be divided into two parts. In the first, she set out her view that and reasoning why the Claimant was a highly vulnerable young person with complex neuro-disability and significant physical needs; epilepsy; respiratory compromise; dystonia, and communication impairment. The arrangements for his care, treatments and therapy, medical oversight, and living environment must be carefully structured to maintain his safety, emotional well-being, and developmental progress. He remained at significant risk of anaphylaxis; respiratory compromise; asthma exacerbation; aspiration pneumonia; seizures; dystonia-related pain; urinary tract infections and constipation. In short, he was medically fragile and required "predictable, consistent, highly trained support." She also explained that the Claimant received speech and language therapy; occupational therapy; physiotherapy (including hydrotherapy) and music therapy in addition to neuro-psychological; neuro-psychiatric; neurological; orthopaedic; ear, nose and throat; respiratory and ophthalmological treatment. The second part of her statement summarised the six primary reasons for her view that a home-based setting would better meet the Claimant's future needs. In short: the importance of regular and spontaneous family contact; an age-appropriate

environment; the risk of institutionalisation; access to the community; logistical concerns and clinical oversight and therapy provision.

59. Cross-examination primarily concentrated on Ms Waters' investigation of the appropriateness of Inspire for the Claimant's future needs. She said that she had checked that it was registered with the CQC; identified its rating; called the home to discuss its facilities and the nature of the rehabilitation provided and the age range of their residents. She had been told that the youngest resident was aged 50 who attended for *ad hoc* respite care. Ms Waters' overall assessment of Inspire was that it was a good facility with one disadvantage, namely the age of its residents. Notwithstanding the Claimant's condition, Ms Waters considered the age factor to be important having regard to his emotional and mental well-being. Ms Waters confirmed that she had recommended that Holy Cross be considered by the Claimant's parents. Ms Waters accepted that she had not carried out an analysis of the competing advantages and disadvantages of the Claimant living in his own adapted home or a residential setting. At best, her view that the former was to be preferred was an interim recommendation which sought to reflect the parents' wishes.

Assessment of the factual witnesses

60. The evidence of DBK and Mrs Brack was criticised by Ms Toogood. The former was said to have been confused and, in parts, even evasive in cross-examination particularly on the question of plans for her son's future care and accommodation. The latter's firm preference for a home-based arrangement was said to lack evidential support and to the extent that Ms Brack sought to say that it was supported by Ms Waters' evidence, that was inconsistent with the contemporaneous documents.

61. The substance of Ms Toogood's criticisms is addressed below, but at this point it is sufficient to say that DBX's love for, and steadfast devotion to, her son was obvious. Her commitment to her son's well-being was clear as was her determination to ensure that he receives the best possible care after he leaves Tadworth Court. For these reasons, DBX may have been anxious about giving an answer which might be thought to undermine her case that domiciliary care will best meet her son's needs. She was understandably apprehensive giving evidence which sometimes revealed itself when she hesitated before answering questions or asked for them to be repeated. She seemed to find the process of cross-examination difficult. DBX's recollection of the chronology and sequence of events was uncertain especially on the reasons for and the timing of her visits to neuro-residential units. All that said, having had the opportunity to consider her evidence and to assess her as a witness, I am not persuaded that DBX was intentionally evasive or seeking to dissemble in any way. When cross-examined about why she decided to appoint Ms Waters as her son's case manager, my impression was that her initial refusal and later reluctance to answer was partly prompted by a concern not to upset Ms Jackson who was in court at the time. Overall, my judgment is that DBX was doing her honest best to help the court.

62. Mrs Brack was an honest and straight-forward witness. The live question, however, is the quality of the reasoning underpinning her view that a home-based care arrangement would best serve the Claimant's reasonable needs. That question is considered below.

63. No criticism was rightly made of the other six witnesses who each gave truthful evidence and were clearly concerned to assist the court.

PART 5 – the expert evidence

Generally

64. This Part summarises the experts' evidence on the principal question of the Claimant's future care and accommodation. I have read and considered the reports of all the experts retained by the parties (including supplemental correspondence) and to the limited extent it is necessary or useful to do so, I have referred to them. As the experts' joint statements identified the material points of agreement and disagreement at trial and so provided the framework for cross-examination and submissions, they provide the starting point for consideration of the expert issues.

Neurology

Overview

65. As indicated above, Dr Prasad and Dr Agrawal were retained by the Claimant and the Trust respectively to act as neurological experts. Dr Prasad's evidence was contained in his reports of April 2023 and December 2024 and a letter dated 28 April 2026. Dr Agrawal's evidence was set out in his reports of September 2022 and December 2025 and a letter dated 15 March 2026.

66. The neurological experts' minutes of discussion (dated 24 March 2026) record their substantial agreement on the Claimant's diagnosis and prognosis. He remains in a minimally conscious state; he demonstrates only intermittent and inconsistent signs of awareness, without any reliable evidence of purposeful interaction, communication or meaningful engagement with his environment. There is no realistic prospect that his level of consciousness will improve and his care is entirely supportive. The Claimant will remain unable to communicate, make decisions or interact meaningfully with others. His awareness will continue to be limited and fluctuating.

67. As to his mobility and manual ability, the Claimant has a profound four-limb motor disorder with mixed spasticity and dystonia. He has no independent mobility or antigravity movements; he has minimal head control and no purposeful use of his upper limbs. He is entirely wheelchair-dependent and requires hoisting for all transfers. The Claimant's needs will be lifelong. The prognosis is one of complete and permanent immobility. Over time, contractures will worsen. His scoliosis will progress contributing to his discomfort and further compromising his respiratory function. There is no prospect of any functional motor recovery.

68. There was no dispute in their assessment of the Claimant's epilepsy and dystonia. As to the former, epileptic episodes have increased over time although their particular frequency and severity has varied. Overall, the trajectory is one of variable seizure control which will increasingly affect the Claimant's daily functioning, sleep and general health. The consequences of the Claimant's worsening epilepsy have been significant and include greater reliance on rescue medication; increased sedation; more

frequent hospital admissions and a heightened risk of a sudden unexpected death in epilepsy. The prospect of a meaningful improvement in seizure control is limited. As to the latter, the Claimant's dystonic episodes are severe, frequent and unpredictable. They present a major source of morbidity. Dystonia has become one of the more unstable and disruptive features of the Claimant's presentation. Its management includes a structured escalation protocol involving comfort measures; clonidine; chloral hydrate; baclofen; gabapentin and regular Botulinum toxin injections. The Claimant's dystonia is likely to remain intractable and may further worsen. The prognosis is one of persistent and worsening dystonia, continuing pain and a significant adverse effect on his quality of life.

69. The Claimant's significant respiratory vulnerability remains his principal life-limiting factor. He suffers from recurrent infections and impaired airway protection which require suctioning; nebulised treatment; oxygen support and hospital admissions.

70. The principal dispute between the experts concerned the advantages and disadvantages of the Claimant living in a home adapted for his needs with a 24-hour care regime compared to a residential rehabilitation unit. Dr Prasad's view was essentially three-fold: first, a home-based model is not inherently unsafe or unsuitable. Indeed, it offered important advantages for the Claimant such as a familiar, low-stimulation setting which is likely to reduce stress and the frequency and severity of his dystonic episodes; greater continuity of care and greater family involvement in his care. Secondly, the Claimant's needs can be met in a home setting if there is an appropriately structured, nurse-led care package including clear escalation protocols and access to community medical and therapy services. Thirdly, a specialist residential neuro-nursing facility can provide a high level of clinical support but it is not the only or clearly superior option. Although its infrastructure may provide certain advantages, the evidence indicates that equivalent care can be given in an appropriately resourced and governed home setting. A specialist facility has disadvantages: a reduced personalisation of care; a diminished continuity of care and a more stimulating and so less predictable environment which may be less well tolerated by the Claimant given his neurological profile.

71. Dr Agrawal accepted that, from the neurological perspective, the perceived advantages of a home-based model related primarily to environmental and psycho-social factors rather than clinical considerations. He acknowledged that a home setting had some benefits: it may offer a quieter and more personalised environment which may serve the Claimant well because he is known to respond better to familiar carers and low-stimulation surroundings. It may also provide greater flexibility in daily routines, increased family involvement and more individualised care provision. Dr Agrawal expressly recognised that these were important considerations and ones which reflected the views of the Claimant's parents and some of his care team.

72. That said, Dr Agrawal identified what he described as substantial and overriding disadvantages. The Claimant has suffered a catastrophic neurological injury with a disorder of consciousness; severe dystonia; epilepsy; profound motor impairment and significant medical fragility. For that reason, the Claimant's care is highly complex and dynamic. It requires continuous monitoring and rapid escalation in response to unpredictable events including epileptic seizures; dystonic crises; respiratory compromise and feeding complications. Dr Agrawal's view was that the Claimant's current care protocols showed that his stability depends upon immediate access to

experienced staff; structured escalation pathways and co-ordinated multi-disciplinary contributions. In short, it would be "extremely challenging" to provide the required clinical infrastructure in a home environment.

The PDOC Guidelines

73. Before turning to the neurological experts' oral evidence, I should note Dr Prasad's supplemental letter of 28 April 2026 which was sent about a month after the joint statement was signed. The letter was prompted by the Trust's relatively late reliance on a document, published by the Royal College of Physicians in 2020, entitled "Prolonged disorders of consciousness following sudden onset brain injury – National Clinical Guidelines" which were described as the "PDOC Guidelines" at trial. Although at p. 4 there is an indication that the PDOC Guidelines were due to be reviewed in 2025, there is no suggestion that a new edition had been published or that the 2020 version has been materially superseded. The PDOC Guidelines will be considered further below, but in her questioning of the experts Ms Toogood primarily relied upon two principal extracts:

(a) At p. 79, in section 3.2.4, it is said that:

> "Long-term care should be provided in an appropriate setting, which may be in the patient's own home with family, but is more usually arranged in a nursing home setting; living alone with a care team is not appropriate …"

(b) At p.80, under the heading "Long-term care in the home", it was advised that:

> " … families are often keen for the patient to be placed at home, but often without any clear understanding of the enormity of the task of caring for them. Patients with PDOC have very intensive and specialist care requirements and it is rarely feasible or practical to provide care in the home setting unless one or more family members are dedicated to providing the role of lead carer. On the other hand, a small number of patients react so positively to family members and home life that care at home is agreed by all the parties to be the best option.
>
> Caring for an individual who has very limited ability to interact is a challenging task for non-family carers, and there are often practical difficulties including recruitment and retention of suitably trained staff.
>
> In the majority of cases, the patient's lack of awareness limits the extent of positive experience that may arise from being at home. Inevitably the household tends to revolve around their needs, which may be to the detriment of others (for example, children) in the home setting.
>
> In many cases, a much better solution may be to provide the majority of care in a nursing home setting, but with the opportunity to spend short periods (usually daytime visits) at home. When planning these arrangements, factors to consider are:

- travelling distance to and from the home and the length of time the patient can sit comfortably in a wheelchair/risk of pressure sores etc
- access into the home, and to facilities within the home, in case of episodes of incontinence or if overnight stay is planned."

74. Dr Prasad was asked by the Claimant's solicitors to comment on the PDOC Guidelines. In his supplemental letter of 28 April 2026, Dr Prasad made four principal points: first, the PDOC Guidelines summarised the general principles concerning the long-term management of patients with prolonged disorders of consciousness and the complexities of providing care in a home setting; secondly, he agreed that the Claimant had "highly complex needs and require a specialist level of care, with appropriate staffing, governance and clear escalation pathways"; thirdly, the PDOC Guidelines did not set an absolute rule that care must be provided in a residential setting in all cases because the appropriateness of one setting over another depends on the individual patient's specific clinical needs; finally, Dr Prasad fairly observed that his role was limited to commenting on the nature and complexity of the Claimant's neurological and medical needs so in other words the feasibility of competing care arrangements was for the care experts. Dr Prasad concluded his letter thus:

> "Accordingly, the guidance does not cause me to alter the opinion expressed in the joint statement, namely that either a specialist residential placement or a properly structured home-based package may be capable of meeting his needs, subject to the views of the relevant care and accommodation experts."

Dr Prasad

75. Cross-examination was chiefly concerned with the Claimant's diagnosis and his future and care and accommodation needs. Dr Prasad accepted that the Claimant was in a prolonged minimal consciousness state and disagreed with Dr Igboekwu's contrary view. Dr Prasad did not resile from or qualify the substance of the joint statement but drew out two particular points in his answers: first, there had been no improvement in the Claimant's consciousness over the past eight years; secondly, respiratory complications remained the principal life-limiting factor but "there are many and that is one of them". On the latter point, Dr Prasad considered that the Claimant's dystonia was one of the most important risks that he faced.

76. As to future accommodation, Dr Prasad accepted that before his without prejudice discussions with Dr Agrawal, he had not been asked to consider, from the clinical perspective, the appropriateness of the Claimant's future care and accommodation.

77. Much time was spent questioning Dr Prasad about the advice in the PDOC Guidelines. Dr Prasad's response was three-fold: first, although he thought the PDOC Guidelines were "very good" nonetheless they gave only guidance. His assessment of the appropriateness of accommodation was informed by a number of factors including his clinical experience (in which many children with a similar presentation to the Claimant lived with their families at home) and the fact that the proposed care package in the Claimant's case was not one usually seen in the community. Dr Prasad also placed particular weight on the social benefits of living at home. Given their nature and consequences, the Claimant's dystonic episodes were a significant risk and the care and

attention given by his mother and others greatly alleviated the significant pain and distress he experienced.

78. Ultimately, Dr Prasad's view was that residential care was not the only option but, on the facts of this case, a home-based model was to be preferred. Although he recognised that caring for someone with the Claimant's needs was challenging, the fundamental requirement of clinical safety ("safety is the number one") could be achieved in a home-setting governed by comprehensive care arrangements with effective contingency plans. That said, Dr Prasad accepted that the clinical infrastructure provided by Holy Cross (which included, among other matters, a service agreement with a local GP practice and a 24-hour on-call service from a team of seven doctors) could not be replicated in a home setting and the Claimant's needs were likely to increase as he became older. He also accepted that, as is the case at Tadworth Court, it was a "definite advantage" to have access to a hospital for interventions such as the administration of oxygen and the infrastructure provided by a residential unit could not be replicated at home. Crucially, however, given the nature of the Claimant's recent medical crises (epileptic seizures and dystonic episodes) he could not see why, given that the same protocols would manage the response, the nature of the setting would make much difference. If application of the particular protocol did not effectively resolve a medical crisis, an ambulance would be called irrespective of whether the Claimant lived at home with his carers or in a neuro-care residential unit.

Dr Agrawal

79. Mr Tyack's questioning concentrated on the Claimant's future care and accommodation. Dr Agrawal's view remained that although a home-based model was not inherently unsafe, it was less safe than a residential unit because it lacked the latter's supporting clinical governance and its clinical infrastructure of robust escalation plans and peer review. Dr Agrawal said that his position was fortified by his clinical experience and his concerns about the (impliedly poor) retention rate of agency care workers. Irrespective of the best designed domiciliary care arrangements, he considered a residential unit to be "far superior and much safer" because of its resilience. Dr Agrawal considered that the Claimant could "produce some engagement with his environment and he can engage with some music, he can engage with some of the football games" but it is not repeatable.

80. Dr Agrawal considered that an awareness of people on the part of the Claimant was not inconsistent with a prolonged disorder of consciousness. On that point, he said that he and Dr Prasad agreed that the Claimant met the definition of minimal consciousness. The question is whether that awareness is consistent and whether any reactions could be reliably repeated. Some reactions were clear: for example, the Claimant was aware of his mother and he dislikes loud noise, a common reaction among those who have suffered a brain injury. However, it would be going too far to say that the Claimant liked a particular age group. Dr Agrawal thought that a large pinch of salt was necessary when considering people's assessments of the Claimant's likes and dislikes but he accepted that if you know someone, you can pick up subtle signs.

81. Dr Agrawal said that the Claimant's quality of life and his safety were "inseparable". The former would be determined by his medical needs and the latter would require a "supreme quality of safety". Dr Agrawal agreed that the Claimant's decline would likely

be gradual unless he was seized by an acute infection. Dystonia was the "worst" and "most difficult" condition to manage and Dr Agrawal accepted that episodes could be triggered by any deviation from the physiological norm. His seizures could be managed but they were unpredictable. Dr Agrawal was cross-examined closely on his view that the Claimant's condition had deteriorated. To that end, Mr Tyack took him through the clinical records and correspondence with a view to challenging that conclusion. Dr Agrawal disagreed: the medical notes were inconsistent with the suggestion that there were no hospital admissions between April 2024 and May 2025; comments in correspondence about the Claimant's stable or improved condition were records of what the treating clinician had been told by others; the overall picture was a "deteriorating trajectory" with "snapshots" of improvement but defined by unpredictability. In summary, Dr Agrawal said that the Claimant had "very complex needs" with a "fragile medical status who needs multi-layered co-ordinated and immediate escalation when the crisis happens and that crisis will not forewarn."

82. As to the care arrangements, Dr Agrawal considered that it was unusual to see a package in which the Claimant lived exclusively with carers and with no family member living with him. He agreed that there were risks in all care settings but the unpredictability of the Claimant's medical crises was the important point. In answer to Mr Tyack's question that there was no difference between the proposed home care package and an institution, Dr Agrawal identified the latter's resilience as the point of distinction. Care at home was not unsafe but it was less safe than an institution. The thrust of his evidence was that the assessment of the neurological risks was integral to the care package. Dr Agrawal accepted that there had been difficulties with the provision of treatment and therapies for the Claimant at Tadworth Court but he did not agree that institutional "blockages" to treatment was a disadvantage of residential care.

83. The important point was the response to the Claimant's unpredictable crises rather than whether there were problems about physiotherapy etc. On that point, although Dr Agrawal accepted that escalation plans would be prepared by the same clinicians irrespective of the Claimant's care setting, in a residential unit those responsible for executing those plans will have the support of "multiple staff, multiple layers of governance and resilience in the system."

84. In relation to hydrotherapy, Dr Agrawal considered the absence of a pool to be a disadvantage.

Assessment

85. Both Dr Prasad and Dr Agrawal are expert in their field and both approached their evidence conscientiously and with the sole purpose of assisting the court. Both experts gave careful and considered evidence and neither strayed outside the limits of their experience and expertise.

Neuropsychiatry

Overview

86. The Claimant instructed Dr Jideofor Igboekwu and the Trust retained Dr Richard Soppitt as their neuropsychiatric experts. Dr Igboekwu provided a report dated 18

January 2025 as well as a letter dated 29 April 2026 and Dr Soppitt's report was dated December 2025.

87. The neuropsychiatrists provided a joint statement (dated 7 April 2026) which set out a large measure of agreement about the Claimant's diagnosis and prognosis. They agreed that he had a major neurocognitive disorder secondary to a hypoxic-ischemic encephalopathic brain injury with associated emotional, psychological and psychiatric disorders. Although Dr Igboekwu diagnosed a moderate depressive disorder, Dr Soppitt acknowledged only anxiety for which sertraline had been prescribed. The latter accepted that a diagnosis of depression was possible but it was difficult to disentangle other issues such as pain, fatigue and adjustment reactions caused by minimal and inconsistent communication and so make a certain diagnosis.

88. The experts agreed that the Claimant's psychiatric and psychological conditions would require lifelong treatment. They endorsed the neurologists' view that rehabilitation was unlikely to be practicable. The realistic aim of care was agreed to be the maintenance of comfort, quality of life and, where possible, the slowing of any deterioration in the Claimant's condition.

89. On the question of the Claimant's future accommodation, Dr Igboekwu supported the home-based model and listed what he considered to be its main advantages: easier and more spontaneous family access; the reduced risk of institutionalisation; a consistent and familiar care team; greater flexibility in arranging therapies and easier access to hydrotherapy. He noted that the Claimant preferred his own space, struggled in shared and noisy settings and was most content in one-to-one situations. Dr Igboekwu placed particular emphasis on an age-appropriate environment for the Claimant, a factor which he counted in favour of a home setting.

90. Dr Soppitt accepted that although a home-based model was theoretically possible, it was unlikely reliably to meet the Claimant's profound and complex needs and is more likely to create stress for the Claimant and his family. A home package had five disadvantages: first, there was a high risk arising from the Claimant's medical complexity, emergency pathways and multiple interlocking conditions, all of which will probably increase towards the end of his life thereby necessitating an unnecessary and risky transition from home to a more supportive intensive placement. Secondly, the difficulty of maintaining a sufficiently skilled and stable care team in the community. Thirdly, the high risk of discontinuity were carers to leave, relationships break down or emergencies occur. Fourthly, there was reduced immediate access to specialist nursing, investigations, multi-disciplinary contributions and crisis response. Finally, the practical challenge of replicating Tadworth Court-level provision in a novel and untested home-setting. Dr Soppitt's overall view was that the Claimant's needs were best met by a highly specialist provision which closely replicated Tadworth Court. In relation to the age question, Dr Soppitt noted that the Claimant had engaged well with adults of all ages at Tadworth Court and often preferred them to people of his own age who may be too noisy or over-stimulating for him. The Claimant had formed close and trusting relationships with middle-aged adults at Tadworth Court. Although the Claimant's parents may find an older resident profile unattractive, Dr Soppitt did not consider this sufficient to outweigh the "best interests" need for safe, continuous and expert neurological care in a tested setting with established on-site expertise.

91. In relation to future treatment and therapies, the experts recommended continuation of the hydrotherapy that the Claimant was receiving at Tadworth Court but deferred to the physiotherapist experts on the substance of the required regime. They thought that the Claimant derived significant benefit from regular hydrotherapy which provided physical comfort, managed his dystonia and regulated his emotions. Dr Igboekwu considered regular and ready access to hydrotherapy an especial factor in favour of a home-based model.

Dr Igboekwu

92. In cross-examination, Dr Igboekwu stood by his view that the Claimant would be better living at home supported by carers. When Ms Toogood suggested various matters that would be the same irrespective of the accommodation model (for instance, each would require two-to-one care; the need for visiting hours to respect the Claimant's sleep patterns and the requirement to make arrangements for hydrotherapy so that a sufficient number of staff could help), Dr Igboekwu held fast to his position. There were two other distinctive features of his cross-examination. Notwithstanding the neurologists' consensus, Dr Igboekwu did not agree that the Claimant was minimally conscious and contended that his condition was progressive and, at one point, seemingly suggested that it had materially improved. His dissent was not satisfactorily explained and he did not provide a reasoned critique of the neurologists' diagnosis. Dr Igboekwu was also asked why his report had not considered the advantages and disadvantages of each of the competing accommodation models. His short answer was that he would not consider any option that made the Claimant unwell.

Dr Soppitt

93. Dr Soppitt also maintained his position on future care and accommodation. His essential view was that, from the psychiatric perspective, if the Claimant were in his best possible physical state, the anxiety and stress of those around him will reduce which, in turn, will improve his quality of life. Mr Tyack pressed Dr Soppitt on the question whether, if medical risk were put to one side, the "environmental state" of his own home would be better for the Claimant. Dr Soppitt answered that the Claimant's environmental state had to be micromanaged and very carefully considered but it was not sensible to discuss accommodation without having regard to medical risk.

94. Notwithstanding sustained questioning on the point, Dr Soppitt considered that, although he deferred to the neurologists on the nature and extent of the medical risk and the care experts on the substance of the required care package, he had the requisite expertise to assist the court on the psycho-social impact of medical risk on the family and carers. On that point, Dr Soppitt's evidence was that the psychological impact of caring for a young person in a minimally conscious state and whose condition was not improving was likely to be significant and "very demanding". For the carers, it was likely to be a "very stressful scenario" and there would be a "higher risk of carer burn out" so they will need "very close" psychological supervision and containment. To that end, Dr Soppitt said it would be useful to have evidence of a successful home regime "but there isn't currently and there hasn't been."

Assessment

95. Dr Igboekwu was plainly concerned to do his best by the Claimant but, in my judgment, he did not sufficiently consider the merits and, crucially, the risks posed by the various accommodation options under consideration. I was concerned by two particular aspects of his evidence. The first was his effective refusal to answer properly Ms Toogood's questions about his failure to consider the disadvantages of a home-based setting and the advantages of a residential unit. The result was that he denied the court the benefit of his experience and expertise on these important points. The second was Dr Igboekwu's dissent about the Claimant's diagnosis, a position which was neither satisfactorily explained nor consistent with the neurologists' considered conclusion. Although he accepted that the question of diagnosis was outside his expertise, nonetheless Dr Igboekwu seemed determined to advance his view in his cross-examination.

96. In contrast, Dr Soppitt was a careful and considered witness. He was obviously aware of his duties to the court and thoughtfully answered questions. I do not accept Mr Tyack's submission that Dr Soppitt impermissibly strayed beyond his expertise in commenting on the psycho-social impact on his carers were the Claimant to live with them in his own home. Such matters are squarely within Dr Soppitt's experience and expertise and his opinion is a legitimate part of the relevant evidence that the court must consider. He repeatedly said that he deferred to the neurologists on the assessment of the nature and extent of medical risk and to the care experts on the appropriate care arrangements.

97. For these reasons and to the extent that there is any disagreement between them on neuropsychiatric matters, I prefer Dr Soppitt's evidence to that of Dr Igboekwu.

Care

Overview

98. Mrs Caroline Evans and Mrs Claire Ward were retained to act as care experts by the Claimant and the Trust respectively. Mrs Evans' evidence was contained in a report dated February 2025 and supplemented by four letters dated 5 March, 2 April, 22 April and 11 May 2026. Mrs Ward's evidence was set out in a report dated December 2025 and two letters dated 14 October 2025 and 23 March 2026.

99. Their joint statement (dated 20 April 2026) summarised the costings of the proposed care options and their views on future care provision. The fundamental difference between the care experts was the appropriateness of a domiciliary or a residential care setting. Mrs Evans preferred the former and Mrs Ward the latter.

100. Mrs Evans concluded that a home setting would be better for the Claimant for three principal reasons: first, it ensured a patient-centred care regime which would best place the Claimant and his family in the position they would have been but for the Trust's negligence; secondly, in her experience a home-based care regime provided by a suitably specialist agency could work well and would allow (a) care to be exclusively designed for and designated to the Claimant, (b) appropriate therapies and treatments to be arranged for his needs and (c) his family (but especially DBX) to have a greater involvement in his care and support; thirdly, if care provision were to deteriorate, the

care provider could be changed without undue disruption. It would be harder to rectify matters if care in a residential unit fell below the required standard.

101. Mrs Evans thought that there were three disadvantages: first, a home-based model is more expensive; secondly, the risk of breakdown is potentially higher than in a nursing care setting but that could be mitigated by retaining an appropriate agency with robust contingency care arrangements; thirdly, if the court did not accept the need for a hydrotherapy pool at home, the Claimant would have to travel to and from a pool which may limit its therapeutic purpose.

102. Mrs Ward acknowledged the benefits of the Claimant living in his own home (primarily those identified by DBX and Ms Waters) but considered that they were outweighed by the greater potential for gaps in provision than a rehabilitation unit. In addition to the disadvantages identified by Mrs Evans, Mrs Ward placed particular weight on the following considerations: first, home-based living is neither the safest nor the most practical option given the complexity of the Claimant's condition; secondly, the family's choice has been for the Claimant to live at Tadworth Court, a specialist rehabilitation unit, for the past eight years; thirdly, it will likely take time to adapt a suitable house and, bearing in mind the Claimant's limited life expectancy, the move may involve disruption at a time when his care needs may be increasing; fourthly, a home-based option would not offer as much stability and consistency as a specialist unit; fifthly, a lone case manager, administering several (geographically dispersed) cases, may be a risk given the absence of support, high levels of stress and burn out and little supervision; sixthly, recruitment of specialist therapists to treat the Claimant at home is often difficult; finally, in light of the neurologists' agreement that daily therapy is warranted, such treatment is often more easily provided by an on-site team.

103. If the court considers that home care is reasonable, the experts agree that the Claimant would require 24-hour care from one nurse and one healthcare assistant.

104. Mrs Ward saw many advantages to the Claimant remaining with the same care model as that provided by Tadworth Court: first, similarity and consistency of care; secondly, the greater degree of safety that flows from the larger pool of support staff, the high degree of regulation and available infrastructure as well as facilities such as a hydrotherapy pool; thirdly, ready access for visitors. Mrs Ward also identified disadvantages including the risk of fluctuating care standards; the risk that a residential unit might close; the fact that residential units may be busier and noisier and its communal area would not be personal to the Claimant and infection control.

105. Although Mrs Evans acknowledged some advantages of a residential unit (primarily expense; the reassurance given by an institutional care package; in-house therapy services and medical support), they were either over-stated or outweighed by countervailing factors. In summary, irrespective of the setting, the Claimant will need his own designated nurse and carer; the Claimant's experience at Tadworth Court illustrated the limits of treatment provision particularly where independent and off-site therapists are required; whichever setting was considered reasonable, if the Claimant's condition deteriorated, he would have to be admitted to hospital. Importantly, Mrs Evans rejected Mrs Ward's characterisation of case management. In her experience, were a case manager to fall unwell, leave would be covered by the senior management team or an alternative manager. Mrs Evans was concerned by the risk of fluctuating

standards of care in a residential unit, a prospect which was exemplified by the Claimant's experience of Tadworth Court.

106. The joint statement also addressed the question of agency care. Mrs Evans advanced Libertatem as an appropriate agency with an "outstanding" CQC rating and experience of providing full-time two-to-one care. She explained the three-tier background support provided by a clinical lead nurse, a field care manager and a care co-ordinator as well as the contingency arrangements. Mrs Evans was confident that Libertatem had the requisite skill and experience to make the care package a success. In response, Mrs Ward maintained her view that a home-based model was not appropriate but, if the court decided otherwise, she suggested that Harmony, another agency, was a suitable alternative to Libertatem.

Caroline Evans

107. Mrs Evans' cross-examination concentrated on the adequacy of her assessment of the merits of residential neuro-care and the appropriateness of a home setting. She accepted that her evaluation of the benefits and disadvantages of the relevant options was confined to a single sentence of her original report and that the nature, extent and results of her research of appropriate residential units was not explained. Until recently it seemed that Mrs Evans was unaware that DBX has visited Bagshot Park or Inspire. Mrs Evans relied upon her experience of making care arrangements for others with similarly complex presentations and identified what she considered to be the downsides of adult residential care: a lack of consistency of care; a potentially less intense care regime for adults compared to Tadworth Court; a diminished degree of appropriate stimulation. That said, Mrs Evans was unable to identify the medical evidence and so the medical risks that she considered before commending a home setting for the Claimant. She accepted that the Claimant's quality of life was determined by his medical needs and that there was a greater risk that a care package might break down at home compared to a residential unit. Mrs Evans accepted that the latter had "built-in resilience".

108. Mrs Evans was also questioned about the practicalities of home-based care arrangements. Should a staff member leave, Mrs Evans said that Libertatem had indicated that notice periods could be agreed by reference to the degree of security the arrangements required. If there were a breakdown, the family would be supported by a three-tier staff system which would work closely with them. That said, Mrs Evans agreed that the extent of medical support available at Holy Cross could not be replicated in a home setting but, given his condition, the Claimant would likely be a high priority for his local GP and so receive home visits as necessary. Mrs Evans accepted, however, that she did not know whether those visits would be daily.

109. In relation to the merits of a home-based setting she had identified, Mrs Evans accepted that the Claimant receives one-to-one care at Tadworth Court but will need two-to-one care at home. She also agreed that the need for a nurse to carry out a care assistant role while necessary at home will not be necessary at a residential unit. Mrs Evans agreed that Inspire, Bagshot Park and Holy Cross would each recruit staff to look after the Claimant just as a care team would need to be engaged should he live at home. Mrs Evans firmly disagreed with Ms Toogood's suggestion that two-to-one care at a residential unit would meet her concern that such institutions would be unable to provide patient-centred care and the family's access to the Claimant would be governed

by its rules. Although Mrs Evans accepted that therapy appointments would have to be fixed irrespective of the accommodation, she said that in a residential unit the timings would depend upon the extent to which, for instance, the therapy gym would be used by others. In answer to questions on the PDOC Guidance, Mrs Evans' view was that its advice did not reflect the reality of a case-managed patient at home who would not be dependent on statutory services which the guidance assumes.

Claire Ward

110. Mr Tyack's cross-examination of Mrs Ward dwelt on two principal points: whether she had the requisite experience to assist the court on the reasonableness of the options before it and her view that a residential unit better served the Claimant's reasonable needs. As to the first, although her experience of private case management was limited to one case, Mrs Ward said that working for local authority social services had given her significant experience of managing care packages, assessing people's safety at home and carrying out other assessments such as occupational therapy. That said, she had never established or managed an agency care package nor had she managed cases full-time.

111. As to the second, although she had raised cost as a relevant consideration when considering the accommodation models, Mrs Ward accepted that it was not the most important factor. In relation to hydrotherapy, it was suggested to Mrs Ward that as the Trust's physiotherapy expert considered that treatment was required twice weekly, Inspire (which had no pool) and Holy Cross (which only had availability for one session weekly) were effectively excluded from consideration. The essence of Mrs Ward's response was that was only so if hydrotherapy was the most important consideration and the absence of a pool was not a good reason to put the Claimant in an unsafe environment in his own home. As to Bagshot Park, it was suggested by Mr Tyack that the room did not have an appropriate "XY" hoist to allow the Claimant to be moved safely and without triggering a dystonic episode to which Mrs Ward responded that it would be the unit's responsibility to make sure that any necessary adaptations would be made to the Claimant's room. Mrs Ward was critical of what she described as Libertatem's claims notwithstanding Mrs Evans' evidence about their experience of caring for other patients whose needs were as complex as those of the Claimant. More generally, Mrs Ward maintained her position in the joint statement that the home-based setting was less safe than a residential unit.

Assessment

112. The care experts' evidence was each problematic but in different ways. The trial was the first time that Mrs Evans and Mrs Ward had given oral evidence. Both experts were understandably nervous and the contrast between the relative clarity of the joint statement and their hesitation in cross-examination was notable.

113. The problems with Mrs Evans' evidence were, however, more fundamental. She did not consider the advantages and disadvantages of the identified home and residential settings sufficiently to satisfy me that she had fully discharged her obligations under

Part 35. Her report of February 2025 did not set out the disadvantages of a home-based care regime or the advantages of residential care arrangements. Indeed, consideration of the Claimant's future care and accommodation was confined to one sentence. The joint statement and Mrs Evans' supplemental letter of 5 March 2026 further illustrated the one-sided nature of her approach. In the joint statement, Mrs Evans effectively advocated in favour of a home setting. The letter recognised that both options had "positives and negatives" but it only identified the positive features of the home setting and the negative characteristics of a residential unit.

114. There were other unsatisfactory features of Mrs Evans' evidence: first and foremost, for reasons which she did not adequately explain, Mrs Evans did not seek any expert medical advice on the appropriate future care setting for the Claimant notwithstanding his complex condition and requirements; secondly, although she accepted in cross-examination that she had researched adult neuro-residential care options for the Claimant, none of her research was set out in the report and so there was no information on which the court had the benefit of her views about those units; thirdly, although Mrs Evans understood the question of the Claimant's reasonable needs was for the court to decide, her report did not include any of the information which the court would require to make that decision; fourthly, Mrs Evans concluded that Libertatem or a similarly experienced care agency would meet the Claimant's complex needs but she had not discussed his case with Libertatem or any other agency. Viewing her evidence in its entirety, in my judgment, Mrs Evans fell into the trap of advocating one side's position rather than providing the court with a full, fair and balanced assessment of the competing merits of the options for the Claimant's future care and accommodation.

115. As to Mrs Ward, I am satisfied that she has the requisite experience and expertise to assist the court on that question. Mrs Ward has managed cases on a daily basis as part of her local authority work for many years and she has experience of home and residential care. I also accept that the title "case manager" is confined to, or at least more often used in, the private sector whereas Mrs Ward's experience was predominantly working for the social services departments of local authorities administering to the needs of those who were dependent upon state support.

116. Mrs Ward's nervousness about giving evidence for the first time manifested itself more starkly than that of Mrs Evans. At one point she seemed unable to concentrate on the question or to give a sensible answer. Towards the end of her evidence, she apologised and said she was tired. Having considered Mrs Ward's evidence and reflected on counsel's submissions, I accept that her nerves overcame her but, inevitably, these matters adversely affected the quality of her oral evidence. That said, in contrast to Mrs Evans, Mrs Ward's report set out the merits of the competing future care arrangements and her preference for a residential unit was explained by reference to expert medical evidence.

117. In assessing the overall strengths and weaknesses of the care experts' evidence, notwithstanding Mrs Ward's somewhat unsatisfactory oral evidence, the weightier factor is Mrs Evans' failure to provide the court with the full and fair analysis which CPR 35 requires and the other unsatisfactory features of her evidence. I regret this conclusion because Mrs Evans is an experienced practitioner who has what she sees as the Claimant's best interests at heart. However, given its centrality in the claim and the complexity of the Claimant's condition and needs, the analysis of future care and

accommodation required greater consideration than the one sentence it received in Mrs Evans' original report and a more balanced assessment in her contribution to the joint statement and her supplemental correspondence. In the circumstances, where there is a disagreement between the care experts, I prefer Mrs Ward's evidence.

Physiotherapy

Overview

118. Mrs Susan Filson and Mrs Juliet Weston were retained to act as physiotherapy experts by the Claimant and the Trust respectively. Mrs Filson's evidence is set out in her report of January 2025 and supplemented by a letter dated 6 May 2026 which considered the pool at Bagshot Park. Mrs Weston's evidence is in her report of December 2025.

119. Their joint statement (dated 2 April 2026) substantially narrowed the issues so that the principal question at trial was the appropriate frequency of the Claimant's access to a hydrotherapy pool. Ms Filson recommended regular daily access to the hydrotherapy pool whereas Ms Weston thought that once or twice weekly was appropriate. At para. 12(b), the physiotherapy experts answered the question about the advantages and disadvantages of a hydrotherapy pool at the Claimant's home or access to one away from his home. The advantages of the former were ease of access; flexibility; no change in air temperature; no travel and daily access. The latter's benefits were the fact that others were responsible for managing the pool and the comparative cost of hiring a community pool as against the cost of building and maintaining one at home.

Susan Filson

120. Although the precise length and extent of her experience was not wholly clear, on any reading of her evidence, Mrs Filson has had experience of hydrotherapy for many years not only as a practitioner but also as a trainer. Four primary points arose from her cross-examination: first, she disagreed with the neurologists' view that hydrotherapy provided no long-term benefit to the Claimant. She considered that it was beneficial in alleviating his dystonic symptoms and spasticity. As her assessment of the evidence was that hydrotherapy relaxed the Claimant, she took that to mean that he enjoyed it. Mrs Filson accepted that, if he received hydrotherapy during the middle of the day, it could make the Claimant tired afterwards and fatigue posed an increase in the risk of him choking. Secondly, there was some confusion about the number of staff that Mrs Filson considered necessary to ensure the Claimant's safety when in the pool. Her eventual view was that there should be two assistants with him in the pool and one out of it. Thirdly, in considering the proposed frequency of the Claimant's hydrotherapy, Mrs Filson was not sure whether daily treatment was a significant imposition on his carers. Finally, in considering the benefits of a hydrotherapy in his house, Mrs Filson emphasised that one of its advantages was flexibility in terms of when the treatment could be taken.

Juliet Weston

121. Mrs Weston has considerable experience of providing hydrotherapy and especially its use in treating children with head injuries. She had no experience, however, of treating adults aged over 19. Four principal points emerged from her cross-examination: first, the hydrotherapy pool at Holy Cross was excellent. By contrast, the pool at Bagshot Park was too small, not deep enough, not flat-bottomed and posed difficulties should the Claimant need to be moved in an emergency. Secondly, Mrs Weston was hesitant about the benefits of hydrotherapy. Its advantage was exclusively palliative and it should not be assumed that an increase in hydrotherapy sessions was necessarily better for the Claimant. To illustrate her evidence, Mrs Weston gave an example of a patient with a similar (but not identical) presentation to the Claimant who was unsettled when his hydrotherapy weekly sessions were increased from two to three. Her essential view was that there was no evidence to support the suggestion that the Claimant would benefit from hydrotherapy on "most days". As she put it towards the end of her evidence, Mrs Weston considered that hydrotherapy had limited clinical value. Thirdly, Mrs Weston pointed out that although he relaxed in the pool, it was not the only source of relaxation available to the Claimant. That said, she accepted that should he need further surgery (for instance, orthopaedic surgery), hydrotherapy may at that stage be beneficial in alleviating his symptoms. Finally, Mrs Weston agreed that a residential unit with a pool was an advantage but not "totally necessary". If the Claimant were required to travel to and from a pool, Mrs Weston accepted that the benefit of the treatment might be lost.

Assessment

122. Both experts understood and discharged their duty to the court and both were expert in their discipline. Having reflected on their evidence, where they disagree, I prefer that of Mrs Weston. Her evidence was calm, measured and analytical. In particular, I was impressed by her considered assessment of the benefits of hydrotherapy and, importantly, its limits. In contrast to Mrs Filson, Mrs Weston critically and thoughtfully considered whether more was, or was likely to be, better in terms of regularity of hydrotherapy sessions absent any supporting evidence. I was also concerned by Mrs Filson's apparent confusion about how many people would be required to ensure that the Claimant was safe during hydrotherapy treatment.

PART 6 – quantum generally

123. As indicated earlier, Counsel agreed the quantum of the future care and accommodation claim if the court resolved the case on one of seven scenarios which they thought may be open to the court. Counsel also agreed that I am not bound to find any particular scenario and I may wish to award damages on a different basis. The agreement was subject to an appropriate mechanism for avoiding double recovery and, importantly, the lost years claim is not part of it.

Scenario	Agreed quantum
1	The Claimant lives in his own home with care provided by Libertatem care agency:

	Retained lump sum £5,990,000 and a periodical payment of £1,061,189 consisting of commercial care (£1,016,007); gratuitous care (£17,500); case management (£10,392) and deputyship (£17,290).
2	The Claimant lives in a neuro-rehabilitation unit with in-house package of therapies: Retained lump sum £3,600,000 and a periodical payment of £724,793.71 consisting of care/accommodation (£685,600); gratuitous care (£17,500); case management (£8,000) and deputyship (£11,730.31).
3	The Claimant lives in his own home with care provided by Harmony care agency: Retained lump sum £5,910,000 and a periodical payment of £911,282 consisting of commercial care (£866,100); gratuitous care (£17,500); case management (£10,392) and deputyship (£17,290).
4	The Claimant lives in his own home with care, hydrotherapy and therapies provided by Bagshot Park: Retained lump sum £5,145,000 and periodical payment of £722,272 consisting of commercial care (£677,090); gratuitous care (£17,500); case management (£10,392) and deputyship (£17,290).
5	The Claimant lives in his own home with care and therapies provided by Bagshot Park but a hydrotherapy pool at home: Retained lump sum £5,760,000 and periodical payment of £722,272 consisting of commercial care (£677,090); gratuitous care (£17,500); case management (£10,392) and deputyship (£17,290).
6	The Claimant lives in his own home with care provided by Bagshot Park but therapies sourced separately and hydrotherapy pool at home: Retained lump sum £5,810,000 and periodical payment of £722,272 consisting of commercial care (£677,090); gratuitous care (£17,500); case management (£10,392) and deputyship (£17,290).
7	The Claimant lives in a neurorehabilitation unit with sufficient funds to source his own therapies, vehicle and additional healthcare assistant for 30 hours per week with activity allowance: Retained lump sum £3,830,000 and periodical payment of £725,222.91 consisting of care/accommodation (£685,600.60); gratuitous care (£17,500); case management (£10,392) and deputyship (£11,730.31).

124. In relation to double recovery, at para. 20 of his written closing submissions, Mr Tyack confirmed that, subject to some refinement of the text, the parties had agreed a reverse indemnity in principle. In essence, sums from the periodical payments which the Claimant did not spend on care or case management would be refunded to the Trust in the following year. Therefore, if the Claimant moved into an institution and did not spend all the periodical payment on care and case management, the remaining money would be re-paid to the Trust. In these circumstances, Mr Tyack submitted (and I did not understand Ms Toogood to object), there would be no chance of double recovery.

125. Notwithstanding the care with which the options were identified and calculated, at trial the central argument was between options 1 and 2. With the exception of hydrotherapy, very little evidence was adduced on the alternatives.

PART 7 – future care and accommodation

Summary of the parties' positions

126. Mr Tyack and Mr Spencer Ley submitted that, at the age of 19, the Claimant should move from Tadworth Court into a home which will be adapted to his needs where he would be cared for by nursing and care staff provided by Libertatem for 24 hours a day, seven days a week and on a two-to-one basis. They submit that the principal question is whether the care and accommodation regime claimed by the Claimant (that is to say, option 1 as set out above) is reasonable. In his closing submissions, Mr Tyack submitted that:

(a) The test is whether the sought-for regime is reasonable. The test is not whether the proposed regime is in the Claimant's best interests. It is not enough for a defendant to show, or for the court to find, that there are other reasonable arrangements.

(b) The clear weight of the evidence indicates that it is likely that, if the Claimant were awarded damages under option 1, he would live in his own adapted home supported by the proposed Libertatem care package. On that point, Mr Tyack placed much weight on DBX's reservations about institutional care and her experience of several incidents at Tadworth Court (notably those in December 2024 and April 2025) in which he said that the standard of care fell below what was required.

(c) Option 1 is reasonable for many of the reasons advanced by Mrs Evans: care will be bespoke to the Claimant; agency nurses and healthcare assistants will be recruited and trained specifically to care for the Claimant; friends and family can visit at any time; additional therapies will be available as and when required and not subject to the vagaries of institutions; if the standard of care deteriorates, the provider can be changed without undue disruption. Mr Tyack also contended that the Claimant's health would be better monitored and supported by GP and weekly consultant reviews. Dr Agrawal ultimately accepted that the proposed care regime was safe but not as safe as an institution. Even if that view were accepted, the proposed regime would still be reasonable.

(d) The agreed sum the parties have allowed under option 1 is reasonable not least because Libertatem is not the most expensive one.

(e) In weighing the expert evidence, the court is invited to prefer the Claimant's experts. In relation to the PDOC Guidelines, they provided only advice; they are primarily concerned with the limits of state funding; they were not cited by any of the experts in their original reports; they are inapt to describe the Claimant's proposed arrangements because he would not be living alone and they do not exclude the possibility of a domiciliary solution in all cases.

(f) As to hydrotherapy, the court is invited to accept the evidence of Mrs Filson and to conclude that daily sessions are reasonable.

(g) In relation to the Claimant's physical condition, Mr Tyack submitted that Dr Agrawal's suggestion in evidence that there was a decline between 2022 and 2025 in most domains over-states the position compared to his own report which indicated that the decline was confined to the period between 2022 and 2024. Mr Tyack also relied upon the relatively few procedures that the Claimant has undergone since February 2022; the recently reduced incidence of dystonic episodes and some favourable assessments of his general health in clinical correspondence. Overall, the Claimant's condition is relatively stable.

(h) As to the Claimant's level of consciousness, Mr Tyack emphasised that he has significant awareness and insight into his situation. As well as suffering a great deal of pain and distress, he feels comfort and experiences pleasure. It was important to the Claimant's well-being that he is cared for by staff who know him well.

127. Ms Toogood's position was that the Claimant has not shown that the home-based model is safe and so reasonable to meet his complex condition and needs. For that reason, the reasonable course is for the Claimant to live at an adult neuro-rehabilitation unit. In summary:

(a) There were two questions under this head: whether the Claimant will incur the expenses he is claiming under option 1 and whether he is entitled to recover damages to meet his reasonable requirements. On the latter point, the Claimant's reasonable requirements are those that are in his best interests. The court cannot decide what is reasonable without identifying what is in the Claimant's best interests.

(b) As to the first question, it was submitted that DBX's evidence was confused and, in places, evasive. DBX had taken no steps to investigate prospective properties; she had not spoken to any care agencies but she had visited Bagshot Park and other units and not mentioned them in her evidence. Their actions indicated that the Claimant's parents were investigating suitable neuro-nursing facilities and not planning to buy a home for him. The Claimant has, therefore, failed to prove that he will incur the losses involved in a home-based arrangement.

(c) As to the second question, Ms Toogood placed weight on the near-complete agreement between the neurological experts; the PDOC Guidelines and Dr Agrawal's view that the perceived advantages of the home-based model were environmental and psycho-social rather than clinical considerations. In particular, the Trust adopted Dr Agrawal's evidence that the necessary clinical infrastructure

to manage the Claimant's complex needs and unpredictable crises could not be replicated in a home-based arrangement.

(d) In weighing the expert evidence, the Trust invited the court to prefer its experts who were said, in contrast to their counterparts, to have complied with their obligations under CPR 35 and considered all relevant matters so as to give a balanced assessment of the respective merits of domiciliary and residential care.

The relevant legal principles

128. Assessment of compensation for an injured party is moderated by what is reasonable. To that end, a judge must resist the temptation to make the wrongdoer pay for the best possible treatment regardless of whether the injured party will in fact receive such treatment or whether it is reasonable for him to receive less expensive treatment: *Rialis v. Mitchell* (1984) WL 282520 per Stephenson LJ at p. 12. Therefore, what should be first considered by the court is not whether other treatment is reasonable but whether the treatment chosen and claimed for is reasonable: *Rialis*, per Stephenson LJ at p. 13. At p. 8 of the report of the *Rialis* case, O'Connor LJ summarised the position thus:

> "There may well be cases in which it would be right to conclude that it is unreasonable for a plaintiff to insist on being cared for at home, but I am quite satisfied that this is not such a case, and once it is concluded that it is reasonable for the infant plaintiff to remain at home then I can find no acceptable ground for saying that the defendant should not pay the reasonable cost of caring for him at home, but pay only a lesser sum which would be appropriate only if it was unreasonable for him to live at home and reasonable for him to be in an institution."

129. In *Sowden v. Lodge* [2005] 1 WLR 2129, the Court of Appeal endorsed the test applied by Stephen LJ and O'Connor LJ in *Rialis*. Two points of principle were identified: first, the judge should not assess damages on the basis of what he considers to be in the claimant's best interests because "paternalism does not replace the right of a claimant, or those with responsibility for the claimant, making a reasonable choice": para. 38, per Pill LJ. Secondly, the correct question is "what is required to meet the claimant's reasonable needs?" not "what is in the best interests of the claimant?" although on the facts of *Sowden*'s case, the answer to the two questions was the same: para. 40, per Longmore LJ.

130. In opening and closing submissions, Ms Toogood used the phrase "best interests" as a synonym for the Claimant's reasonable requirements and submitted that it was not possible to determine what was reasonable without examining what was in his best interests. I am not persuaded that this approach is correct. As set out in *Rialis* and *Sowden*, the test is "what is required to meet the Claimant's reasonable needs?" On the facts of *Sowden*'s case, those needs and the claimant's best interests were the same but the law is concerned to find the damages that meet the Claimant's reasonable needs. Reference to "best interests" obscures the clarity of Longmore LJ's statement of principle in *Sowden*.

131. In *CCC v. Sheffield Teaching Hospitals NHS Foundation Trust* [2023] EWHC 1770 (KB) Ritchie J considered the role and relevance of proportionality in the assessment

of future special damages. At para. 113 of his judgment, he identified "two gates through which the claimant must pass to obtain an award of future special damage under any head": first, does the claimant have a reasonable need for the expense as a result of his injuries, pain, suffering, loss of amenity with the twin aims of gaining some benefits and taking steps towards putting him back into the same position he would have been but for the injuries? Secondly, are the claimed expenses reasonable compared with the other less expensive methods of satisfying the reasonable need and taking those steps?

132. In *Harman v. East Kent Hospitals NHS Foundation Trust* [2015] EWHC 1662 (QB), at paras. 36 and 37 of his judgment, Turner J said that care must be taken not to equiparate the family's preferences with the regime of care and support the cost of which should be the basis of reasonable compensation. That does not mean that the family's wishes are necessarily irrelevant but each case must be examined on its facts.

Discussion

133. As counsel agreed, the first question is whether the Claimant will incur the costs of buying and adapting a home and setting up a Libertatem-operated care arrangement. The second is whether option 1 is reasonable. I will deal with each in turn.

Will the Claimant incur the costs claimed?

134. DBX's consistent evidence was that her ideal outcome is for the Claimant to live in his own home, supported by his own team of carers. ABX made much the same point. Importantly, both parents had reservations about the standard of care that the Claimant might receive in an adult residential unit. DBX's concerns were particularly prompted by what she considered to be serious failings in the care provided to the Claimant at Tadworth Court revealed by the incidents in December 2024 and April 2025 and the quality and effectiveness of their subsequent investigation. Those concerns were echoed in and confirmed by the case manager's report into the latter incident. It is also clear from the evidence of Mrs Brack, Ms Jackson and Ms Waters that there have been difficulties securing certain treatments for the Claimant (but especially speech and language therapy), all of which added to DBX's concerns about the adequacy and appropriateness of institutional care. ABX referred more generally to "horror stories" about adult care homes. DBX's experience of the Claimant's time at Southampton in the immediate aftermath of his injury was deeply unhappy and it has informed her views about the quality of institutional care and its suitability for her son. There is no doubt in my mind that, irrespective of their merits, the Claimant's parents' reservations about residential care are sincere and they have shaped, if not decided, their preference for a home-based setting.

135. The Trust placed much weight on Dr Igboekwu's report of DBX's worry that the Claimant might miss the "buzz" of (that is to say, the atmosphere at) Tadworth Court were he to live in his own home. However, Dr Igboekwu said that DBX was "thinking aloud" when she made the comment in August 2024 and there was nothing in the evidence to suggest that she had reached a final and considered view of the respective merits of domiciliary and residential care at that time. In any event, as Mr Tyack submitted, the suggestion that the Claimant enjoys the atmosphere of Tadworth Court is not inconsistent with the uncontroversial evidence that he prefers his own company and dislikes the noise of the communal areas.

136. The Trust also relied on the absence of any reference in DBX's three statements (including the most recent one signed on 6 March 2026) to her visits to adult neuro-care residential units. These visits should have been addressed in her evidence and there was some force in Ms Toogood's submission that DBX did not satisfactorily explain their omission. However, as set out above, I did not find DBX to be an evasive witness as opposed to one who found the process of cross-examination difficult. Given the Trust's position on care and accommodation and the risk that it might be accepted at trial, it would be surprising if DBX had not visited adult neuro-rehabilitation residential units if only as a precaution. Her prudence is not inconsistent with her ideal outcome.

137. Another argument made by the Trust is that the Claimant's parents have not yet looked for suitable houses for the Claimant, an omission which it said to be inconsistent with their case that he should live in his own home. I am unpersuaded by this point: unless and until their options are clarified by this judgment, little purpose would be served by searching for houses that may well have been sold by the time DBX and ABX are ready to buy.

138. A relatively more troubling aspect of DBX's evidence was her inability to explain when and why she had decided that a domiciliary model would best meet the Claimant's reasonable needs. She had also not shared her plans for the Claimant's future care with Tadworth Court or Fran Huntley, the Claimant's social worker even though the documentary evidence showed that in October 2024 it was recommended that preparation for the Claimant's transfer from Tadworth Court should start. On 17 April 2026, the social worker had recorded that the "parents expressed that they were not ready to engage in detailed future planning until clearer options are formally presented". As the Trust submitted in closing, there was no reason for DBX not to tell Fran Huntley or Tadworth Court about her future plans for the Claimant's accommodation even on a contingent basis. In other words, DBX could have explained her preference for a home-based solution but the final decision rested on the court's decision.

139. Although DBX and ABX could have been more open with Ms Huntley and Tadworth Court, the reality is that, as they indicated at their meeting with the local authority on 24 February 2026, they are waiting for the outcome of the trial before discussing future accommodation and care options in any detail. As Mr Tyack argued (and I accept), that position is consistent with an intention to move the Claimant into his own home if he is awarded sufficient damages to enable him to do so.

140. Accordingly, I am satisfied that, if enough money is available, a house will be bought and adapted for the Claimant and appropriate care arrangements put in place.

Is Option 1 reasonable?

Preliminary points

141. Before turning to the substantive question, I should address two preliminary points: Dr Igboekwu's evidence on the Claimant's diagnosis and the relevance of, and the weight to be attached to, the PDOC Guidelines.

142. Given the clear terms of the neurologists' consensus on the Claimant's diagnosis and his acceptance in his letter of 29 April 2026 that the diagnosis of disorders of consciousness was outside his expertise, I do not accept Dr Igboekwu's contention that the Claimant does not suffer from a prolonged disorder of consciousness. Indeed, it was expressly rejected by Dr Prasad. It was unfortunate that notwithstanding the clear terms of his letter, no such restraint was obvious in Dr Igboekwu's oral evidence.

143. The Trust placed much weight on the PDOC Guidelines and, in particular, the extracts quoted at para. 73 above. Neither neurologist cited the PDOC Guidelines in their reports but both considered them to be sound. Indeed, Dr Prasad thought them "very good". There was no dispute about the authority or distinction of the members of the working party who produced them or that of Professor Lynne Turner-Stokes MBE who was responsible for their overall drafting. The PDOC Guidelines were endorsed by (among others) the Royal College of Physicians, the Royal College of Nursing, the Royal College of Occupational Therapists, the Association for Palliative Medicine, the British Psychological Society, the British Society of Rehabilitation Medicine, the Chartered Society of Physiotherapists and the Faculty of Intensive Care Medicine. They were also supported by the Association of British Neurologists and the British Medical Association.

144. As their title suggests, the PDOC Guidelines provide general but limited advice on long-term care of a patient with a prolonged disorder of consciousness. They were prepared by a distinguished working party whose work has been endorsed by an authoritative body of opinion in the medical profession. There is nothing in the PDOC Guidelines to support Mr Tyack's submission that its primary purpose was to advise on the limits of public funding although in practice they may be used for that collateral purpose. However, the general advice is confined to the single sentence quoted in para. 73 above and the short phrase that living alone with a care team is not appropriate. The extract from p. 80 is chiefly concerned with cases where a patient lives at home primarily supported by family members but without a 24/7 carer support. That is not what option 1 proposes and so the relevance of that extract is not immediately clear. Overall, the PDOC Guidelines form part of the evidential picture but they are not determinative of the reasonableness of option 1 or in judging the quality of the expert evidence.

Consideration of option 1

145. To identify what is required to meet Claimant's reasonable needs, the starting point is his diagnosis and prognosis set out in the neurologists' joint statement which I accept. As they agreed and I find, the Claimant is and will remain severely disabled. He is and will remain in a minimally conscious state and there is no realistic prospect that his level of consciousness will improve. His care is entirely supportive. He has a profound four-limb motor disorder and the prognosis is one of complete and permanent immobility. The future progress of the Claimant's epilepsy is likely to be one of variable seizure control which will increasingly affect his daily functioning, sleep and general health. Among other risks, there is a heightened risk of sudden death. The Claimant's dystonia is both unstable and disruptive and his episodes are severe, frequent and unpredictable. It is likely to become intractable and may worsen further. Importantly, the Claimant's significant respiratory vulnerability is his primary life-limiting risk but, as Dr Prasad said, it is only one of many such risks confronting him.

146. For the reasons set out in the neurologists' joint statement and echoed by Dr Soppitt, the Claimant's clinical needs are and will remain profound and complex. For that reason, Dr Prasad said that "safety is the number one" and Dr Agrawal observed that the Claimant's quality of life and safety were "inseparable". In cross-examination, Dr Agrawal described (and I accept) the Claimant's "very complex needs" and his "fragile medical status" which needed "multi-layered co-ordinated and immediate escalation when the crisis happens and that crisis will not forewarn". His description is entirely consistent with the substance of the neurologists' joint statement.

147. The expert assessment of the complexity and fragility of the Claimant's condition was reflected in the factual evidence. Mr O'Reilly said that the Claimant was one of the most highly medicated residents under his care when he worked at Chestnut House. That evidence was borne out by his evidence-in-chief which contained the lengthy itemisation of some 40 or so prescription medicines, supplements and treatments provided to the Claimant; the protocols which managed six of the conditions from which he suffers and the complexity of feeding him and administering his medicines. Ms Waters described a highly vulnerable young man with complex neuro-disability and significant physical needs who was at risk of many acute threats including (but by no means confined to) anaphylaxis, respiratory compromise, seizures and dystonia-triggered pain. Mrs Bower's evidence gave a practical idea of the nature of the challenges in caring for the Claimant. Sometimes his mother's voice calms him and so avoids a dystonic episode but sometimes it does not and so other ways need to be tried. In other words, what works to alleviate the Claimant's symptoms one day may not the next.

148. There was some debate at trial about the nature and extent of the Claimant's awareness, a matter on which Dr Agrawal was also cross-examined. The short point is that Dr Prasad and Dr Agrawal agreed (and I find) that the Claimant has only intermittent and inconsistent signs of awareness which will continue to be limited and fluctuating. Neither Dr Agrawal nor Dr Prasad withdrew or qualified their common opinion in cross-examination. Because of the fluctuating nature of the Claimant's awareness, Dr Agrawal advised (and I find) that some caution should be exercised when considering people's assessment of a patient's likes and dislikes although someone who knows the Claimant well could pick up signs about his preferences.

149. Subject to its limited, intermittent and inconsistent nature, I accept the Claimant is aware of his mother and others (such as his carers) who are well known to him. I also accept that, as with others who have suffered a catastrophic brain injury, he dislikes noise. I am not, however, persuaded that the Claimant has sufficient awareness that he would prefer to live with people of his own age or that living with older people would in some way adversely affect his emotional health. The neurologists' conclusion about the nature and severity of his condition and his limited and fluctuating awareness does not support that contention. Dr Soppitt noted in the neuro-psychiatric joint statement that the Claimant had engaged well with adults of all ages at Tadworth Court. Indeed, he seemed to prefer them to people of his own age who could be too noisy and loud. Dr Soppitt's evidence is consistent with the clear and consistent theme of the carers' evidence that the Claimant dislikes noisy environments and prefers to be in his own room with carers who are familiar to him. Ms Waters' evidence that, should the Claimant transfer to an adult neuro-rehabilitation unit, the age of the other residents

would be relevant to his emotional and mental well-being is inconsistent with the agreed neurological evidence, Dr Soppitt's evidence and the weight of the carers' evidence.

150. There was also a question whether the Claimant's condition had deteriorated between 2022 and 2024/5 on which Dr Agrawal was cross-examined. Four points arise from the evidence: first, as was agreed in closing, the Claimant has fortunately required fewer recent hospital admissions; secondly, the general theme of the clinical correspondence (dated 11 November 2025, 19 November 2025 and 1 December 2025) is that the Claimant is in good general health but, as Dr Agrawal pointed out in cross-examination, the descriptions of his condition in those letters record the carers' reports and not the relevant specialists' clinical opinion on examination; thirdly, Mr Tyack's submission is inconsistent with the neurologists' consensus about the Claimant's increasing epileptic episodes, the medical staff's variable control over them and the unstable and intractable nature of his dystonia; fourthly, except as a challenge to Dr Agrawal's credibility, the point is irrelevant to the assessment of damages under this head because there is no evidence that any deterioration will trigger any material increase in the Claimant's care needs and therefore its cost. Ultimately, as Dr Agrawal said in evidence, the clinical picture is one of a deteriorating trajectory, a view which accords with the neurologists' joint statement and which I therefore accept.

Mrs Evans' evidence

151. My assessment of Mrs Evans' evidence is set out in paras. 113 and 114 above but her failure adequately to consider the advantages and disadvantages of the two principal accommodation and care options was illustrated by the fact that only one sentence in her 117-page report was dedicated to assessing the Claimant's future accommodation and care needs. That sentence, at para. 3.03(b)(i), was no more than an assertion: "Whilst there are adult care settings that may be appropriate, I do not consider that [the Claimant] would receive the consistency of care or the appropriate level of attention and stimulation in an adult care setting." As set out above, I am not satisfied that Mrs Evans remedied that deficiency in her contribution to the care experts' joint statement or in her supplemental correspondence. The short point is that Mrs Evans neither critically nor adequately examined the merits of domiciliary and residential care given the catastrophic nature of the Claimant's injury and the fragile and unpredictable nature of his condition. The result was, as I found above, Mrs Evans did not discharge her obligations under CPR 35.

152. The unanimous expert and lay view is that the Claimant has profound and complex medical needs which Dr Prasad described as "immense". For reasons which were not satisfactorily explained, notwithstanding the nature and scale of those needs, Mrs Evans did not seek any expert medical advice before stating a firm view in favour of domiciliary care. Although I do not doubt Mrs Evans' experience, it was no substitute for seeking expert medical advice on the Claimant's condition and needs and critically analysing whether a home-based setting was appropriate. Tellingly, it was not clear that by the time of the trial Mrs Evans had properly considered both parties' neurological and neuropsychiatric expert evidence to inform her own view on the merits of the two principal options before the court.

153. Mrs Evans also did not ask Libertatem (or any other care agency) whether the Claimant's needs could be adequately met by them before stating in her report that those

needs could be supported by a care agency. In evidence, Mrs Evans said that she had subsequently contacted Libertatem to discuss the Claimant's case. In contrast to Mrs Ward who sent detailed letters to each of the three neuro-residential units she contacted for the purposes of costing, there is no written evidence that sets out the information Mrs Evans gave Libertatem (or any other care agency) about the Claimant's condition and needs. In closing, the Trust submitted that the court is being asked to award the Claimant £1,016,007 per annum without any evidence that Libertatem (or any other care agency) has assessed him and confirmed that it is able to provide the necessary care arrangements. There is considerable force in this criticism.

154. Mrs Evans' evidence was the foundation of the Claimant's case in support of option 1. However, for the reasons summarised above, I am not satisfied that she adequately examined and considered its merits or those of residential care and so I am unable to accept her evidence.

The medical expert evidence

155. The Claimant also relied upon Dr Prasad in support of option 1. For some reason, he was not asked to consider the Claimant's future accommodation and care needs before the joint statement and so his first two reports of April 2023 and December 2024 were silent on the point. Dr Prasad's evidence on the point was considered and he was careful to explain why a home-based setting was not inferior to a neuro-residential unit. In the joint statement, he was conditionally inclined in favour of a home-based solution provided that appropriate safeguards and clinical governance arrangements were in place. His letter of 28 April 2026 was, however, ambivalent: he said that both domiciliary and residential care settings were capable of meeting the Claimant's needs. Accordingly, he expressed no preference between them.

156. The advantages Dr Prasad identified in the joint statement and in evidence in favour of home-based care were, as Dr Agrawal observed and I find, essentially psycho-social: a relatively quieter and more personalised environment with the consequential benefits for the Claimant's dystonia and a greater degree of flexibility in arranging treatments and trips.

157. Those matters should, however, be considered in the broader context of the Claimant's condition. An important, if not the principal, issue is whether the nursing and care staff in a home setting would be able to respond effectively to a medical crisis. On the evidence before the court, I am not satisfied that the proposed domiciliary option would be able to do so. The Claimant's condition is complex, fragile and dynamic. As Dr Agrawal said (and I accept), an effective response to the inevitable medical crisis depends upon experienced staff, clear and structured escalation plans and co-ordinated multi-disciplinary contributions. If it is assumed that a domiciliary setting may be able to provide suitably experienced staff, there would not be ready and immediate access to the range of clinicians who may be necessary to ensure the Claimant's stability and, importantly, the effective implementation of escalation plans. In contrast, the weight of the expert evidence (including that of Dr Prasad) is that such access would be available were the Claimant to live in a neuro-residential unit and supported by the discipline and benefit of institutional governance and peer-review arrangements. Dr Soppitt made much the same point when he contrasted the nursing and care arrangements at home to

the specialist nursing, investigations, multi-disciplinary contributions and crisis response arrangements more readily available in an institution.

158. Linked to this point is Dr Soppitt's evidence (which I accept) that the high risk presented by the Claimant's medical complexity, the emergency protocols and his multiple interlocking conditions will probably increase towards the end of his life. If the Claimant were to live in a home setting, there would likely be a need to transfer him from home to a more supportive intensive setting, a move which will carry its own risks. As Dr Prasad also said in cross-examination (which I also accept), the Claimant's needs would likely increase as he grew older. The evidence of both specialists reinforces the importance of readier access in a residential setting to the range of clinicians who will be needed to ensure the Claimant's quality of life compared to a home setting.

159. The unfortunate reality is that the Claimant's life expectancy (25½ years of age) is another relevant consideration in evaluating option 1. The neurologists agreed that if his respiratory health deteriorated, there would likely be an acute respiratory event leading to the Claimant's death. Dr Prasad thought that the Claimant's condition would deteriorate over a few months or even weeks. Dr Agrawal put the point differently and described an "acute on chronic" event. The neurologists' consensus also demonstrates the importance of readier access to the various clinical disciplines that may be needed to respond to a medical crisis at the end of the Claimant's life.

160. Both neurological experts emphasised the central importance of clinical safety in considering the Claimant's future care arrangements because it is fundamental to his medical needs and quality of life. Mr Tyack placed weight on Dr Agrawal's answer that option 1 would be safe and so, it was submitted, reasonable. This submission does not, in my judgment, fairly reflect the entirety of Dr Agrawal's evidence, the essence of which was that there were substantial disadvantages to the proposed home-based care arrangements. As he said in cross-examination (and I find), the Claimant's medical needs require a "supreme quality of safety" and the proposed domiciliary setting was, in his view, less safe than a neuro-care residential unit because it lacked the required institutional infrastructure and resilience.

161. The Claimant also relied upon Dr Igboekwu. In contrast to Dr Prasad, he had been asked to consider the appropriateness of a home-based setting and institutional care. At this point, it is sufficient to note that I did not find him to be a persuasive witness for the reasons set out in paras. 95-97 above.

162. Although the ultimate difference between Dr Prasad and Dr Agrawal on the Claimant's future arrangements was less than first appeared in their joint statement, I am not satisfied, for the reasons given above, that option 1 would provide adequate support for the Claimant's profound and challenging clinical needs.

The factual evidence

163. In considering whether option 1 meets the Claimant's reasonable needs, I have carefully considered the Claimants' parents' wish for him to live in his own home, supported by a team of carers who are well known to him. I have kept at the forefront of my mind, his parents' reservations about institutional care and, in particular, his mother's view of the standard of care provided at Tadworth Court which resulted in the incidents in

December 2024 and April 2025. Two points arise: first, I remind myself of Turner J's observation in *Harman*'s case that care should be taken not to equate parental preference with the care arrangements which should form the basis of reasonable compensation; secondly, it is clear that the December 2024 and April 2025 incidents have weighed heavily on DBX's mind and the potentially fatal consequences should the Claimant not receive the consistent standard of care that his complex presentation demands. That said, irrespective of whether the Claimant lives in his own home or in a residential unit, he will receive two-to-one care at all times which should address DBX's concerns.

164. I am not satisfied that Mrs Brack, the Claimant's joint deputy, properly considered the merits of domiciliary and residential care before concluding that the former met the Claimant's reasonable needs. She had neither read nor considered the neurologists' reports or taken any separate expert medical advice. Notwithstanding the Claimant's complex condition and needs, Mrs Brack took no meaningful steps to inform herself about the advantages and disadvantages of the home-based and residential settings. When Ms Toogood pursued the point, Mrs Brack said that her preference for a domiciliary solution was based on Ms Waters' advice but that cannot be right. Ms Waters, a qualified nurse, prepared an initial needs assessment report (dated 11 February 2026) (i.e. about a month before Mrs Brack signed her statement on 10 March 2026) in which she advised, at para. 16, that a further detailed review of the risk and benefits of each solution was required as part of future planning and long-term care provision. No such review was done. In any event, Mrs Brack's letter of instruction to Ms Waters (dated 16 October 2025) stated that "it is our case that [the Claimant] will need independent accommodation when he reached 18 years of age." It also appears that Mrs Brack had not contacted any care agency to inform herself about the merits of the available future accommodation and care options. It was therefore surprising that Mrs Brack felt it appropriate to advance such a firm view in favour of a home setting when she had not sought expert medical advice to assess whether it was safe or contacted a care agency to see whether it was feasible. For these reasons, I cannot accept Mrs Brack's evidence.

Hydrotherapy

165. Although much time was devoted to the question of hydrotherapy at trial, the contentious point between Mrs Filson and Mrs Weston was narrow: whether the Claimant should receive daily hydrotherapy sessions or twice-weekly treatment. All experts agreed that hydrotherapy was beneficial to some degree and the Claimants' carers unanimously agreed that he seemed to enjoy being in the pool. As set out above, I preferred Mrs Weston's evidence and, for those reasons, I am not satisfied that there is any sound or critically-evaluated evidence that more than twice-weekly sessions would provide much, if any, substantive therapeutic benefit (or, to use Mrs Weston's phrase, clinical value) to the Claimant.

Conclusion

166. The Claimant has not established that option 1 would meet his reasonable needs. In my judgment, a neuro-residential care unit would satisfy those needs and so I award damages on the basis of option 2, that is to say, the Claimant lives in a neuro-rehabilitation unit with an in-house package of therapies.

PART 8 – the lost years claim

Summary of the parties' positions

The Claimant's submissions

167. The Claimant seeks damages for his loss of earnings and pension in the "lost years", that is to say, the period between the date of his expected death (agreed by the parties as 25½ years of age) and the date of his death had he not been injured (in other words, normal life expectancy.)

168. Mr Spencer Ley submitted that there are three elements to consideration of his head of loss: first, an assessment of the Claimant's likely annual income over his lifetime (net of tax and National Insurance); secondly, calculation of the multiplicand by making an assessment of the percentage of the Claimant's income which he would have spent on his personal living expenses and deduct that from the net income figure; finally, application of a multiplier from the Ogden tables which is discounted to reflect early receipt.

169. As to the first element, Mr Spencer Ley relied upon the chapter concerned with child claimants in *Kemp & Kemp* and para. 60 of Lord Reed's judgment in *CCC*. The short point is that if there is no evidence of a claimant's likely earnings, the court may have to rely on average earnings figures from the Annual Survey of Hours and Earnings ("**ASHE**"). A claimant may, however, contend that he would have earned more than average earnings by relying upon educational achievements; his family's educational and occupational achievements and his geographical situation (whether the family lives in an area of high employment or unemployment). Mr Spencer Ley relied on a decision by Rose J in *Cassel v. Riverside Health Authority* [1992] PIQR Q1 (upheld on appeal) which illustrated the court's approach to assessment of this head in the case of a child who had developed cerebral palsy due to a brain injury at birth. He came from a wealthy and successful family who planned to educate him privately. The claimant's loss of earnings was assessed on the basis that he would have become a partner in a medium-sized City law or accountancy firm. On that basis, the average non-manual salary was uplifted by 50%.

170. As to the second element, Mr Spencer Ley cited an extract from *Kemp & Kemp*, taken from the judgment in *White v. London Transport Executive* [1982] QB 489, which summarised the court's approach thus:

> "A young man living at home with his parents may be regarded as having an available surplus of 33 per cent of his net earnings. When he gets a flat of his own, the available surplus may fall to 25 per cent. But when he marries, the available surplus may rise to 50 per cent since one half of the joint expenditure will not count as part of his living expenses. And, as his family increases, the available surplus will increase as indicated in the examples already considered …"

171. Although Mr Spencer Ley accepted that it is open to the court to assess different percentage deductions for different periods of time, in practice a conventional discount

of 50% has been made by the courts. Relying upon para. 62 of Lord Reed's judgment and para. 158 of Lord Stephens' judgment in *CCC*, he submitted that the Supreme Court had endorsed this approach. Mr Spencer Ley also relied on first instance decisions in which the conventional discount had been applied including *JR v. Sheffield Teaching Hospitals* [2017] 1 WLR 4847; *Fitzpatrick v. Ministry of Justice* [2024] EWHC 3609; *Najib v. John Laing plc* [2011] EWHC 1016; *Crofts v. Murton* [2009] EWHC 3538; *Shanks v. Swan Hunter Group* [2007] EWHC 1807 and *Eagle v Chambers* [2003] EWHC 3135.

172. On the facts of this case, Mr Spencer Ley submitted that:

(a) As to annual income, it is assumed that the Claimant would have followed in his father's family's footsteps and followed a career in sales and eventually achieving the same salary as his father. In such circumstances, it would be unfair to make an assessment on average earnings.

(b) Both sides contend that different annual amounts should be awarded according to his likely earnings at different stages of his life.

(c) The Claimant relies upon his school reports (which in his last year before his accident show that his grades were either good or satisfactory) and his key stage 1 results which show that he was working at the expected standard. Reliance is primarily placed on his father's career as a sales manager in a large international IT company in the City and his brother's hopes to secure a position in sales in due course. As to environment, the Claimant lived with his mother in Crowthorne in Berkshire where the unemployment rate is 3% compared to a national rate of 3.7%. In relation to the question of his pension, the Claimant has pleaded detailed calculations of the alleged loss in contrast to the Trust which has pleaded, without explanation, annual pension and lump sum figures. The court is invited to prefer the Claimant's calculations subject to any adjustment that the court may make about the Claimant's likely income.

(d) In relation to the deduction for living expenses, the Claimant argues for the conventional 50% figure for the entirety of his life. The reality is that the Claimant's living expenses would have varied throughout his life and he is not to be treated as an eternally single man. The Trust's proposed discount of 90% is said to be completely out of kilter with the reported authorities. Mr Spencer Ley observed that there has never been a case in which a 90% discount has been made.

(e) As to the multiplier, Mr Spencer Ley said that it should be capable of agreement but the Claimant's calculations are based on the assumption that by 2079 (when but for his injuries the Claimant would have turned 70), the state retirement age will have increased to 70. By contrast, the Trust's calculation assumes that the pension age will be 68. In practice, all changes to the pension age go in one direction: it is a virtual certainty that the pension age will increase from 67 in the years before 2079.

The Trust's submissions

173. The Trust's submissions concentrated on the two contentious points in relation to assessment of the lost years claim: the level of the Claimant's future loss of earnings and the level of living expenses to be deducted.

174. As to the former, neither the updated nor the revised Schedules of Loss (dated 12 March 2026 and 28 April 2026 respectively) were amended to reflect ABX's actual earnings as set out in HMRC's letter of 9 December 2025. In any event it is inappropriate to use ABX's earnings or those of DBX to predict the Claimant's future earnings: *Oliver v. Ashman* [1961] 1 QB 337 at 344 (per Lord Parker LCJ) and *CCC* [2026] UKSC 5, paras. 184-196 (per Lady Rose). Average earnings should be used to estimate future earning capacity in accordance with the approach applied in *Croke v. Wiseman* [1982] 1 WLR 71: *CCC* [2026] UKSC 5, paras. 44-47 (per Lord Reed); para. 121 (per Lord Burrows) and para. 204 (per Lady Rose).

175. As to the latter, the Claimant has adduced no evidence of his potential living expenses and so it could be argued that he has failed to prove his loss. But the Trust has decided to take a pragmatic approach and to adduce its own evidence from the Office of National Statistics ("**the ONS**"). There is no conventional approach to the discount in child claims because they were not allowed before the *CCC* decision. The Trust relies upon guidance given by Lord Burrows in paras. 141 and 142 of his judgment in *CCC* to the effect that the percentage discount would be high because of the high degree of uncertainty in child claims (paras. 141 and 142) and Lord Stephens' view that it is for the court to determine the appropriate rough-and-ready percentage deduction for living expenses (para. 158).

176. On the evidence in this case, the Trust submits that a discount of 90% is appropriate to reflect the difficulty of the exercise, the degree of speculation required and Lord Burrows' expectation of a high discount. There is no submission that a broad brush *Blamire*-style lump sum award would be appropriate.

177. I should also add that in oral closing submissions, Ms Toogood placed relatively greater reliance on Lady Rose's dissent in *CCC* than in her written submissions. However, she did not explain the jurisprudential basis on which I was not bound to follow the majority's judgment.

The relevant legal principles

178. Until the Supreme Court's recent decision in *CCC*, it had been understood that the law did not recognise claims for the lost years by child claimants. The context of the *CCC* decision was the reasoning in three cases: *Pickett v. British Rail Engineering Limited* [1980] AC 136, *Gammell v. Wilson* [1982] AC 27 and *Croke* [1982] 1 WLR 71.

    (a) In *Pickett*, the House of Lords was concerned with the victim of the tort's inability to earn remuneration during the lost years. Although the claimant was an adult who had developed mesothelioma as a result of occupational asbestos exposure, some of the speeches referred in *obiter* comments to the difficulties proving loss of earnings in the lost years in a child's claim. Lord Wilberforce observed that no award could be made in such cases because the difficulties in assessment were even greater than those concerning adolescents. Lord Salmon considered that in the case of a young

child, lost earnings were so unpredictable and speculative that only a minimal sum could be awarded.

(b) In *Gammell*, the House of Lords decided that the victim's right to recover damages in respect of the lost years in accordance with *Pickett* could be asserted in a claim brought after the victim's death on behalf of his estate. In the first appeal, the deceased was a 15-year-old boy. Lord Scarman stated that in claims by young children, the lost years of earning capacity will ordinarily be so distant that assessment is speculative.

(c) In *Croke*, the Court of Appeal was concerned with a claim brought on behalf of a child who had suffered a severe injury at the age of 21 months causing total disability and a much-reduced expectation of life. Lord Denning MR concluded that no award should be made for the loss of a lifetime's earnings or for the lost years. Griffiths LJ and Shaw LJ disagreed in relation to the former but agreed the latter. Essentially, Griffiths LJ considered that, for reasons of social policy, there were compelling reasons for making an award for the lost years in the case of a living claimant of mature years because the damages would be available for the support of his dependants after his death. By contrast, in the case of a child, there were no dependants. Accordingly, a child claimant was not entitled to a lost years award.

CCC

179. The question before the Supreme Court in *CCC* was the correctness of the decision in *Croke*. As Lord Reed made clear, the court's consideration assumed the reasoning in *Pickett* and *Gammell* was not challenged. The court had also heard no argument on the basis on which damages for pecuniary losses during the lost years are awarded (para. 5) and little argument on the method by which damages for the lost years should be assessed (para. 6). That said, all members of the court agreed four basic propositions:

(a) *Pickett* established, and *Gammell* confirmed, that damages for pecuniary losses during the lost years are recoverable in English law.

(b) *Pickett* and *Gammell* do not restrict lost years damages to claimants who have, or may in the future have, dependants.

(c) Lost years damages are in principle available to claimants who were injured during early childhood provided that the loss can be proved in accordance with normal principles.

(d) To calculate damages for the lost years, it is usual to apply a multiplier derived from the Ogden tables reflecting the number of lost years (i.e. the difference between the claimant's actual life expectancy and the life expectancy which the claimant would have enjoyed but for the injury), but discounted so as to allow for the fact that a lump sum is being given now instead of periodical payments over those years (and also to allow for any contingencies not already taken into account), to a multiplicand reflecting the net annual loss during that period (i.e. the loss of annual income net of tax and after deduction of the claimant's probable living expenses).

180. Lord Reed, with whom Lord Briggs agreed, concluded that the reasoning in *Croke* was unsatisfactory. There was no reason in principle why a claimant's ability to obtain an award in respect of his own pecuniary losses should depend upon the existence of dependants. The claim for lost years is in respect of the claimant's own loss and not anyone else's.

181. In relation to the assessment of the lost years claim, Lord Reed noted that a precise assessment of the loss suffered was not always possible: para. 54. He recognised the many contingencies involved in the attempt to forecast the child's likely earnings and, in relation to the lost years, the likely living expenses if he had not been injured. But he also acknowledged that is always true of a claim based on the loss of future earnings and uncertainty is something which the court should take into account. That assessment should be evidence-based but the law does not insist on proof that events would in fact have taken place. In short, difficulty of assessment is not a reason for awarding no damages or merely nominal damages: para. 55. The evidential difficulties caused by the defendant, in inflicting a severe injury on a young child, should not be allowed to deprive the child of just compensation. The court has to assess damages as best it can on the available evidence: para. 58.

182. As to the method of assessment, at paras. 60 and 62 of his judgment, Lord Reed made four points that are relevant to the present exercise: first, actuarial tables, such as the Ogden tables, reduce the difficulty in determining the appropriate multiplier where a loss will be sustained in the distant future; secondly, the use of statistical evidence of average earnings as a guide to what a child might have earned but for the injury is an important development as is the practice of leading evidence about the educational achievements, occupations and attitudes and evidence about the average earnings of a suitably tailored category of individuals; thirdly, evidence about a range of likely outcomes, based on family circumstances and attitudes, is not mere prejudice or stereotyping. Such evidence is likely to assist the court in making the best assessment it can of the loss suffered by the particular individual who has brought the claim; fourthly, once the probable income has been assessed, the appropriate deduction to make in respect of living expenses need not present any greater difficulties in the case of a child claimant than an adult.

183. Lord Burrows concurred with Lord Reed and Lord Briggs and his essential reasoning is similar. In short, there is no principled objection to a child recovering a lost years award and its quantum should depend on the normal principles and practice of proving loss. To that end, any difficulty in assessing such damages can be addressed by applying a conventional rough-and-ready discount: paras. 140 and 141. In relation to proof of loss, Lord Burrows noted, at para. 121, that practice had become more sophisticated since *Pickett*, *Gammell* and *Croke* to the extent that the use of actuarial evidence is now standard practice which means that awards "based on averages as the best starting approach, is now accepted and applied on a daily basis in the assessment of damages for personal injury."

184. Lord Burrows reviewed the relevant authorities on lost years following *Croke*. Two aspects of the case-law are broadly relevant to the assessment of lost years claims by child claimants: awards made to adolescents and calculation of the living expenses deduction.

(a) As to the former, Lord Burrows referred to two cases in which adolescents had received lost years awards: *Wooding v. Torbay District Council* [1992] CLY 1558 in which damages were given to a 16-year old boy but subject to a 75% discount to reflect living expenses and *Eagle v. Chambers (No. 2)* [2003] EWHC 3135 (QB) where lost years damages were made to a female claimant, aged 17 at the time of the accident, subject to a discount of 50%. Lord Burrows also cited *JR v. Sheffield Teaching Hospitals NHS Foundation Trust* [2017] 1 WLR 4847: paras. 130 and 131.

(b) As to the latter, Lord Burrows noted that in practice a rough-and-ready percentage reduction approach was usually adopted in calculating a lost years award: paras. 134, 135 and 141. There is no reason why such an approach cannot be sensibly applied in respect of young children "even if the percentage discount is high because of the high degree of uncertainty involved": para. 141. The point was repeated in para. 142 where Lord Burrows said that, in calculating lost years awards, he would anticipate that, assuming a multiplier approach is applied, "there will be a high deduction from lost earnings for living expenses. I also accept that, because of the high degree of uncertainty involved, a court may be entitled to decide that it has no real alternative to taking a broad brush approach rather than the usual multiplier approach". That said, Lord Burrows anticipated that usually, the multiplier approach will be applied, based on the Ogden tables, but with a high percentage deduction for the claimant's living expenses: para. 150(ii).

185. Lord Stephens also gave a judgment with which Lord Briggs concurred. He too agreed with Lord Reed but wished to emphasise "the duty on the judge to assess damages in circumstances where a cause of action has been established and a loss sustained": para. 152. For present purposes, two points from Lord Stephens' judgment are relevant: first, the assessment of lost years awards "calls for moderation with due regard to the vicissitudes of life, but the obligation remains to assess the loss and to award compensation for the undoubted loss which has been sustained": para. 154. Secondly, the difficulties in assessing claims can be addressed by making a rough-and-ready discount for living expenses: para. 158. Such a discount should not be arbitrary or artificial so caution must be applied to simply always using a standard or conventional percentage discount. Indeed, uncertainty should not lead a court to make inappropriately parsimonious awards. The trial judge's task is to decide on the facts of the case on a rough-and-ready basis whereabouts in a spectrum of the amount spent by an individual on living expenses will fall and then apply the appropriate percentage discount. The overall assessment calls for moderation.

186. Lady Rose gave a dissenting judgment. Following a review of the authorities, she concluded, at para. 164 of her judgment, that there was a principled distinction between an adult claimant and a child claimant seeking a lost years award. In the case of an adult, the court will have evidence of his or her individual characteristics and abilities. Based on that evidence, the court can make findings about what that person would have achieved in their working life but for the relevant injury. Where the claimant is a child, there is no evidence about how that individual would have grown and developed. Instead, the court is required to assess damages on the basis of assumptions about the child's future abilities, opportunities and earning power based on factors such as gender and family background including class. Evidence that an individual was a member of a cohort and that that segment of society could be used as a proxy for which a claimant

would have been likely to earn was insufficient as it did not relate to the individual claimant. Pertinently, Lady Rose was not persuaded that the absence of evidence in child lost years cases could be satisfactorily addressed by the existence of the Ogden tables which (a) do not identify the annual earnings figure to which the tables' multipliers apply and (b) do not calculate the discount for living expenses.

The evidence

187. In addition to the evidence of DBX and ABX about his school career and interests, Mr Spencer Ley relied upon the Claimant's school reports to give some idea of his academic potential before he suffered his injury at the age of eight.

188. In his end-of-year report for Year 1 (aged 5-6), the Claimant received a positive report. It was said that he enjoyed all subjects but particularly PE. He was enthusiastic in science lessons. His grades in individual subjects were either "excellent" or "good".

189. In 2016, the Claimant's progress at key stage 1 was assessed. He was in Year 2 (aged 6-7). In English reading, English writing, mathematics and science he was working at the expected standard. He was thought to have made good progress in writing and reading and expected progress in mathematics. In history, geography, music, computing, art, and design technology he received a "2" for both effort and attainment, that is to say, good and at the expected level. He received a "3" for effort in religious education and PSHCE (satisfactory) and a "2" for attainment. Notably, the Claimant received "1s" for effort and attainment in PE, i.e. excellent and above the expected level.

190. In Year 3 (aged 7-8), the final full school year before his injury, his results were either "good" or "satisfactory". He received "excellent" in PE.

191. As to the Claimant's family's educational and occupational background, ABX left school aged 15 and started a career in sales. He now works as a sales manager at an international IT firm in the City of London. The summary of his career history and gross earnings provided by HMRC (dated 9 December 2025) ("**the HMRC summary**") shows that his earnings in his first year of employment (1989/90) were £2,992. In the last three years shown in the HMRC summary (2022/3; 2023/4 and 2024/5) his gross earnings were £221,144.04, £160,838.45 and £165,208.26 respectively. ABX comes from a family of salesmen (both his father and grandfather worked in sales) but there is no evidence on the wider family's educational or occupational achievements.

192. DBX left school at 16 and worked as a hairdresser until her children were born. From 2014, she worked as a fashion stylist in department stores but she has not worked since 2018. Her tax records indicate that her first year's earnings were £752 in 1993/4 which increased to £24,212 by 2006/7.

193. The Claimant's brother left school aged 16 and pursued an apprenticeship in business administration. He is now working full-time in an unspecified (but non-sales-related) job but he is said to hope to follow in his father's footsteps. His annual earnings are approximately £14,000.

194. As to environment, the ONS data indicates that the unemployment rate in Bracknell Forest in 2023 was 3% compared to a national rate of 3.7%.

Discussion

195. All members of the Supreme Court in *CCC* recognised that considerable evidential uncertainty arises when seeking to assess a lost years claim brought by an injured child because he cannot point to an established pre-injury earning capacity. This case is a practical example of those difficulties: the Claimant was only eight years old when he sustained his catastrophic injury and, for obvious reasons, there is no evidence about his pre-injury thinking about his future career preferences or much meaningful evidence of his likely pre-injury earning capacity.

196. The first stage is the assessment of the Claimant's likely income. Contrary to Ms Toogood's submission, Lord Reed said that various sources of evidence were relevant to this exercise including (but not confined to) statistical evidence of average earnings, evidence of the Claimant's family's educational and occupational achievements as well as evidence of average earnings of a "suitably tailored category of individuals". Here, the practical question is whether the Claimant's likely income should be assessed on the basis of his father's income (to reflect ABX's evidence that it is likely that he would have followed his father into sales) or on the basis of ASHE's survey of average non-manual earnings.

197. As to the Claimant's immediate family's educational and occupational achievements, his father and mother left school aged 15 and 16 respectively and his elder brother also left secondary education at the age of 16. Both his parents started full-time work after leaving school and his father followed the family tradition and went into sales where he has remained for nearly 40 years. Although the Claimant's elder brother is said to have stated a hope to go into sales, he has yet to do so. Following his apprenticeship (which I assume was successfully completed), he is in full-time employment but in an unspecified sector.

198. Given the precedent of his parents and brother, it is reasonable to assume that the Claimant would have left school aged 16. It is also reasonable to assume that, like his brother, he would not then have immediately entered the workplace but enrolled on an apprenticeship course at the end of which (presumably, after two years) he would started full-time work at or about the age of 18. Whether he would or could have worked in sales is, on the limited evidence, unclear. Notwithstanding the paternal family tradition, the Claimant's brother has not done so. He embarked upon an apprenticeship in business administration and his present job is not, as I understand it, sales-related. There is no evidence about the relevance of the apprenticeship course to sales or, for example, whether it is an expected qualification for, or an established precursor to, a sales job in the City of London or elsewhere. There is also no evidence about the efforts the Claimant's brother has made to secure work in sales if that is his ambition or why he has not done so yet.

199. I remind myself that, as Lord Reed observed, the law does not insist on proof that events (such as the Claimant going into sales) would have taken place but, viewing the limited evidence in the round, I am not satisfied that there is enough to allow me safely to assess the Claimant's likely earnings on the basis of his father's career in sales. ABX may have

wanted the Claimant to continue the longstanding family tradition but his eldest son's experience suggests that his wish would not necessarily be fulfilled. The reports from the Claimant's first three years at school provide very limited assistance in considering his likely employment when he reached 18 and his earning capacity beyond the fact that he was meeting expected standards of development at the age of eight. In the circumstances, the Claimant's likely loss should be assessed on the basis of the most recent ASHE data on net average salaries pleaded in para. 115 of the updated Counter Schedule.

200. The second stage is calculation of the multiplicand and the controversial question of the discount to be applied to reflect the percentage of the Claimant's income he would have spent on personal living expenses. Although assessment of the appropriate discount in child claims will be rough and ready, nonetheless it is an evidence-based exercise. The high degree of uncertainty about the Claimant's likely employment will be relevant as well as the need for moderation and avoidance of unduly parsimonious awards. Assessment should also guard against the reflexive use of a conventional figure. In short, the discount should be decided according to the facts of the case.

201. The parties have cited and I have read various first instance decisions and reports in support of their competing contentions. It is useful to see how other judges have approached the same exercise and the range of discounts allowed (usually (but not always as *Woodley* showed) in the region of 40-50 per cent), but reasons are rarely given to explain the discount applied which limits the help they can provide.

202. In deciding the appropriate discount, in addition to my conclusion on the Claimant's likely future employment, the following factors are relevant:

(a) As the Court of Appeal found in *Harris v. Empress Motors Limited* [1984] 1 WLR 212, the sum to be deducted as living expenses is the proportion of the Claimant's net earnings that he would spend to maintain himself at the standard of life appropriate to his case. Any sums expended to maintain others do not form part of the Claimant's living expenses and are not to be deducted from his net earnings. In reality, the Claimant's living expenses would have varied during his life: if he lived with his parents, his expenses would be small; if he lived alone in his own house, his expenses would be greater; if he married and had children, his personal living expenses would decrease.

(b) It is not possible safely to calibrate the discount according to the various contingencies at different stages of the Claimant's future life. Therefore, consistent with the general approach in adolescent and adult claims, a single discount should be applied to the entirety of this head of loss.

(c) Because he was only eight years old when he sustained his catastrophic injury, there is no reliable evidence of his pre-injury earning capacity.

(d) There is no reason to suppose that he would have been eternally single (to use O'Connor LJ's phrase in *Harris* [1984] 1 WLR 212 at 231).

(e) There is also no reason to suppose that the Claimant would have moved far away from the south-east of England because his parents and elder brother have all

remained in that region. His father is in Cambridgeshire and his brother still lives with his mother in Surrey. The ONS data for Bracknell Forest (where his mother lives) indicates that the unemployment rate is lower than the national average.

203. Having regard to the facts of this case and the factors identified above, the appropriate discount is 50 per cent. Even allowing for the novel nature of the exercise in child claims, the Trust's proposed discount of 90 per cent is, as Mr Spencer Ley submitted, out of kilter with the general range of discounts applied in recent years.

204. The final question is the multiplier. I have been reassured by Mr Spencer Ley that, subject to one point, it can be agreed by the parties following the hand-down of judgment. There is, however, a disagreement about the Claimant's likely retirement age. The current state retirement age is 67 and, as the Claimant submitted, it has only ever gone up and there is no reason to doubt that trend will not continue. For that reason, the Claimant's proposed retirement age of 70 is more realistic than the Trust's alternative of 68.

Conclusion

205. The lost years claim is allowed on the basis that, in relation to the first stage of the assessment, the Claimant's future loss of earnings is calculated according to the average net salary figures set out in the most recent ASHE survey of October 2025 and pleaded in para. 115 of the updated Counter Schedule. As to the second stage, the appropriate discount to be applied to the Claimant's loss of future earnings is 50 per cent and, in relation to the final stage, calculations should proceed on the basis of a retirement age of 70.

206. Having resolved the disputed points between the parties, I should be grateful if they could agree the sum to be awarded under this head.

Conclusion

207. I shall deal with any consequential matters either on the papers or, if necessary, at a hearing. In the meantime, I should be grateful if the parties could prepare an order which reflects my conclusions set out in paras. 166 and 205 above.

208. I am also grateful to Ms McGlynn for her help and efficiency in assisting the witnesses with the trial bundles which was a considerable undertaking.