Neutral Citation Number: [2013] EWHC 1641 (QB)

Case No: 4MA21456

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Manchester District Registry
1 Bridge Street West
Manchester M60 9DJ

Date: 19/06/2013

Before :

MR JUSTICE KENNETH PARKER

- -

Between :

KRISTOPHER LOUGHLIN (By his mother and litigation friend, Barbara Anne Kennedy, formerly known as Loughlin)	**Claimant**
- and -	
(1) KENNETH DAL SINGH	
(2) PAMA & CO LIMITED	
(3) CHURCHILL INSURANCE COMPANY	**Defendants**

- -
- -

Mr David Allan QC and Mr Ivan Bowley (instructed by **Pannone LLP**) for the **Claimant**
Mr David Heaton QC (instructed by **DWF LLP**) for the **Defendants**

Hearing dates: 15 - 22 January and 24 January

- -

Approved Judgment

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

.....

MR JUSTICE KENNETH PARKER

Mr Justice Kenneth Parker :

Introduction

1. On 28 October 2002, when he was 12 years old, the Claimant was seriously injured in a road traffic accident. He was riding his bicycle when he was struck by a vehicle driven by the First Defendant. This was a trial for an assessment of damages, in which a number of contested issues fell to be resolved.

The Claimant's Injuries

2. Following the accident the Claimant was taken to the Manchester Royal Infirmary ("MRI"). He had suffered a comminuted depressed frontal fracture of the skull with a left subdural haematoma. In addition, there was a fracture to the left femur, haemarthrosis and ligamentous damage to the right knee. There was a 4th cranial nerve palsy and multiple abrasions to the face, abdomen and limbs. On admission to the MRI the Claimant's Glasgow Coma Scale was between 6 and 7 out of 15. The Claimant was transferred to the Royal Manchester Children's Hospital.

3. On 29 October 2002 the Claimant underwent operative treatment involving burr hole drainage of the left subdural haematoma, debridement of the skull fracture and insertion of an intracranial pressure monitoring bolt. CT scans of the brain on 29 and 31 October revealed generalised brain oedema and contusion of the left frontal region. The Claimant remained in intensive care under heavy sedation until 3 November 2002 when he was transferred to a high dependency unit. On 8 November 2002 he underwent operative treatment to plate the fractured femur. The Claimant remained in hospital until 22 November 2002.

4. The Claimant's head injury was severe and has resulted in damage to the left frontal lobe of the brain. The Claimant's powers of motivation, initiation and organisation are greatly reduced. On formal testing, the Claimant's IQ is well preserved but outside a structured setting the Claimant struggles to utilise his intelligence. His cognitive abilities are quickly overloaded and he rapidly becomes fatigued.

5. The Claimant has made a good recovery from his other injuries. In March 2004 he underwent operative treatment for removal of the plate from the left femur.

The Claimant's Family and Educational Background

6. The Claimant's father had left the home when the Claimant was aged 9. There was a history of abuse directed at other family members, with some records suggesting the Claimant may have been abused by his father. The Claimant's parents divorced in May 2000. The Claimant's mother began living with Richard Kennedy in September 2000. The Claimant developed a close relationship with his stepfather.

7. The Claimant attended St Mary's RC Primary School. He made good progress academically. His conduct was good. At age 11 the Claimant transferred to St Anne's RC School. He had completed his first year at this school before the accident and had made a promising start. After the accident he returned part-time to school in about January 2003. The Claimant was not able to achieve at his pre-accident level. The Claimant received assistance from a special educational needs co-ordinator

("SENCO"). He received some one-to-one tuition. The Claimant was eventually referred to a consultant paediatrician, Dr Berchtold, who, in a letter to SENCO of 16 June 2006, stated:

> "He continues to suffer from poor organisational skills, poor auditory recall, excessive tiredness and distractability …"

The Claimant was granted additional time for all his GCSE exams. The extra time and additional assistance enabled the Claimant to obtain 2Bs and 5Cs at GCSE level.

8. The Claimant pursued an A level course at Aquinas College. The difficulties flowing from the Claimant's head injury and disabilities were recognised by the college. He was allowed 25% extra time in exams and was to take exams in a separate room with a prompter. He was later provided with a scribe. Dr Berchtold wrote to the college in May 2008 giving an updated assessment and stating that the Claimant's "near complete academic failure in his time at Aquinas" was a consequence of the head injury. After three years at the college, with extra support and extra time in exams, the Claimant achieved grade Es at music technology and psychology and D at general studies. He failed applied business.

9. After finishing at Aquinas College in June 2009, the Claimant was offered a place at Stafford University to pursue an HND course in music production. He failed to organise any finance or accommodation and did not take up the place on the course.

The Claimant's History Since Becoming an Adult: Outline

10. The Claimant remained under the care of Dr Berchtold and the doctors at the Winnicott Centre, until reaching adulthood. He was referred to adult services in March 2009 and was seen by Dr Khan. The Claimant was also referred to a clinical psychologist, Dr Brown, for treatment.

11. In early 2009 a case manager, Beverley Wild, was appointed for the Claimant. She arranged for an occupational therapist to contact the Claimant and make an assessment. He was still at Aquinas College. Following completion of his studies at Aquinas and the failure of the Claimant to take up the place at Stafford, arrangements were made for the Claimant to commence a course in music production in November 2009 at the MIDI College in Salford, requiring him to attend lectures for 6 hours on one day a week with time spent in a music studio on two other days.

12. The Claimant was seen to be vulnerable in social situations. He had a tendency to stare at individuals and would attempt to beg cigarettes from strangers. In December 2009 the Claimant suffered a serious assault at a bus stop, sustaining fractures to his jaw.

13. Arrangements were then made by the case manager for the Claimant to leave his mother's home and move to a flat in the centre of Manchester. The Claimant was initially to have 24 hour support and the plan was to reduce the support gradually and to identify the extent to which the Claimant could live independently. The Claimant moved to a flat on 8 April 2010. Support was removed on some nights, with a support worker remaining on call. The conditions in the flat then deteriorated. The Claimant's sleep pattern also worsened so that he failed to go to bed until the early

hours of the morning and failed to get up until the afternoon. More extensive support was restored.

14. Within a short period of the Claimant moving to a flat, his stepfather was diagnosed with a terminal illness. This diagnosis and illness had an adverse effect on the Claimant. His stepfather died in January 2011. This was followed by the suicide of a friend of the Claimant in February 2011. Also in February 2011 the Claimant was arrested for being drunk and disorderly and stealing a chocolate bar. Following an explanation from one of the support works no charges were preferred.

15. In 2009 the case manager sought assistance for the Claimant from a neuropsychologist. The Claimant attended appointments with Dr Perry-Small but treatment had to be discontinued when Dr Perry-Small moved his practice to London. An alternative neuropsychologist was identified, Dr Colbert, but the Claimant did not find the session useful. An appointment was made for the Claimant to see another neuropsychologist, Dr Gemma Hague, in December 2010. The Claimant found the sessions with this specialist helpful and Dr Hague has remained involved with his treatment.

16. The Claimant's sleep pattern remained a problem. An appointment was made for the Claimant to be examined by a Consultant Neurologist, Dr P N Cooper, who had a special interest in sleep disorders. The Claimant saw Dr Cooper on 24 October 2011. Dr Cooper made a series of recommendations designed to improve the Claimant's sleep pattern. The case manager engaged the assistance of an occupational psychologist, Gwendy Gibson. She began working with the Claimant on a regular basis, providing vocational rehabilitation. Dr Hague arranged for the Claimant to have counselling at TRU, which commenced in October 2011 on a weekly or fortnightly basis.

17. Through the intervention of Ms Gibson, arrangements were made for the Claimant to participate in RSPCA dog walking and undertake voluntary work at a radio station. The Claimant found the advice of Ms Gibson and the counselling at TRU helpful. The Claimant then began to follow the recommendations of Dr Cooper. He agreed to start an 8 week sleep improvement programme in February 2012. The Claimant generally followed the sleep programme and agreed to its extension.

18. The present level of support is that the Claimant has a support worker throughout the day and a sleep-in support worker at night, save for Friday and Saturday nights when support ceases at 10pm. Support resumes at 10am on Saturday and 1pm on Sunday. The sleep regime is followed on the remaining five nights a week. The Claimant continues to receive the advice and assistance of Gwendy Gibson and counselling at TRU.

The First Issue: Capacity

19. The parties are in dispute as to whether the Claimant has capacity to conduct litigation and manage his property and affairs. Section 2 of the Mental Capacity Act 2005 ("the 2005 Act") provides:

> "(1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a

> decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.
>
> (2) It does not matter whether the impairment or disturbance is permanent or temporary…"

Section 3(1) of the 2005 Act provides:

> "For the purposes of section 2, a person is unable to make a decision for himself if he is unable—
>
> (a) to understand the information relevant to the decision,
>
> (b) to retain that information,
>
> (c) to use or weigh that information as part of the process of making the decision, or
>
> (d) to communicate his decision ... "

The principles to be applied for the purposes of the Act are contained in Section 1 and include:

> "(2) A person must be assumed to have capacity unless it is established that he lacks capacity.
>
> (3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
>
> (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision."

20. The leading authorities on capacity are *Masterman-Lister v Brutton & Co* [2002] EWCA Civ 1889 and *Bailey v Warren* [2006] EWCA Civ 26. In *Masterman-Lister*, Kennedy LJ cited with approval a passage from the judgment of Boreham J in *White v Fell 1987* unreported:

> "To have that capacity she requires first the insight and understanding of the fact that she has a problem in respect of which she needs advice … Secondly, having identified the problem, it will be necessary for her to seek an appropriate adviser and to instruct him with sufficient clarity to enable him to understand the problem and to advise her appropriately … Finally she needs sufficient mental capacity to understand and to make decisions based upon, or otherwise give effect to, such advice as she may receive."

21. If the Claimant is vulnerable to exploitation or is prone to make rash or irresponsible decisions, he does not necessarily lack capacity. However, the Court in reaching its conclusion may take such matters into account. In determining capacity the Court has

to consider the individual claimant and the particular context, including the fact that the Claimant would have control of a substantial fund: *Dixon v Were* EWHC [2004] 2273(QB), para 54.

22. I turn now to the expert medical evidence. On behalf of the Defendant, two expert witnesses gave evidence that the Claimant had capacity within the meaning of the legal definition. Dr Schady MD FRCP, a consultant neurologist, produced a written report, dated 13 January 2011, having examined the Claimant on 28 October 2010, (in the presence of an occupational therapist and support worker) and having seen extensive educational, hospital, GP records and medical reports. After making a detailed review of relevant matters, Dr Schady stated his conclusions, as follows:

> "… Neuropsychological testing has revealed that he is functioning cognitively at an average level in most areas but this may still be lower than his pre-accident abilities. This applies particularly to his memory.
>
> More importantly, he shows features of executive dysfunction, i.e. impaired ability to plan and organise. Initiation, decision making and motivation are also affected. He is slower at processing information than he would have been but for the head injury. These deficits are not severe but they are sufficient to undermine his college work and future employment potential.
>
> Psychological issues have also arisen …
>
> He has good social skills ….
>
> I believe he has the ability to understand explanations he may be given with regard to his legal and financial affairs. If he receives appropriate advice he can weigh up alternative courses of action. The vulnerability referred to earlier might put him at risk of manipulation but not, in my opinion, to the extent that he cannot make informed decisions. If he had access to a large sum he would probably make sensible choices, especially if reliable advice were readily to hand." (My emphasis)

23. Dr Schady made further reports, dated 28 February 2011 and 15 July 2011, dealing with the Claimant's circumstances and level of core support. In his view the correct approach was "to reduce the amount of support worker input, concentrating it on periods when their intervention [was] more likely to be required". On 3 August 2012 Dr Schady updated his first report, taking into account, among other information, the support worker and case management records. Dr Schady stated in particular:

> "The second area of concern has been demotivation. This is a feature of frontal lobe damage but it can also occur in depression and lassitude for other reasons. The extent of his executive dysfunction is a matter for the clinical neuro-psychologists involved in the case but there are hints from his behaviour that it is not severe. He has not engaged in

> aggressive or anti-social conduct except when under the influence of alcohol. He is able to engage appropriately with friends and pursue activities that are to his liking. As I understand it, he is popular within his social circle. His apathy does not extend to music or his work at PURE Radio. I would therefore agree with Dr Moss that his demotivation is selective and behavioural, even though there is probably an organic core."

24. Specifically as to mental capacity, Dr Schady stated:

> "This view [lack of capacity] is based on a habit of impulsive buying, for example, purchasing more guitars that he can afford. I am not persuaded that this is sufficient to overturn the presumption of capacity. The question is not whether he makes unwise decisions but whether he has the ability to weigh up the consequences of his actions … I remain of the view that, provided he has appropriate and timely advice, he can understand such advice and use it to arrive at an informed decision. He thus retains the mental capacity to litigate and manage his financial affairs." (My emphasis)

25. In oral evidence to the Court Dr Schady emphasised that the Claimant would be dependent on sound advice in the proper management of his affairs, especially in respect of significant financial decisions:

> "I think it hinges on the availability of advice. I don't think that it can be assumed that he would act sensibly if he were in possession of a large sum of money and not able to access – readily access – advice on what to do with it.
>
> With regard to the first, I think there is a vulnerability there. If he is under the influence of alcohol, if he is tired then it could be that ill-intentioned advice would be taken on board by him and not properly processed. Indeed, he might agree to something – I don't know what it might be, for example: why don't you join me in some business venture? In the light of the next morning, and particularly in the light of the advice that I would suggest would be received from others, my view is that he would then renege on any such agreement. I think I mention in one of my reports that I think it would be perfectly sensible for him to have any monies that accrue from the settlement of the case into a trust fund, to ensure that advice is readily available when it comes to major items of expenditure. So I think that as long as there is the proviso that somebody is readily available to advise him and correct any misapprehensions that may have arisen at times when he is fatigued or intoxicated, I think that he would be safe to make reasoned decisions." (My emphasis)

26. Dr Alan Moss, a consultant neuropsychologist, also produced a detailed expert report on behalf of the Defendant, dated 10 March 2011. Dr Moss carried out a number of relevant assessments. On the Wechsler Adult Intelligence Scale – III (WAIS-III), the Claimant obtained a Full Scale IQ of 120 (superior range), a Verbal IQ of 117 (high average range) and a Performance IQ of 121 (superior range). He also was assessed as having a Verbal Comprehension Index of 120 (superior range) and a Perceptual Organisation Index of 128 (superior range). Dr Moss concluded that "the results of the WAIS-III do not indicate any significant impairment of general intelligence". As to attention and concentration, the results from the tests did not reveal any significant deficit in visual scanning, simple sequencing, attentional switching, multitasking, motor speed, immediate attention span, working memory or processing speed.

27. Dr Moss's conclusion was as follows:

> "**10.4** I also note that there are consistent reports that Mr Loughlin has difficulty organising and motivating himself. The post accident school records indicate deterioration in performance although this was by no means severe. Nevertheless, bearing in mind the severity of his injury and the age at which it occurred, it is likely to have resulted in Mr Loughlin experiencing significant difficulties with his studies and integrating with his fellow pupils. It is likely that this change in ability level and difficulty with integration resulted in a significant mood disturbance. Further, it would also appear that Mr Loughlin did not understand the nature of his difficulties and did not fully understand what had happened to him. This would have added to his emotional difficulties.
>
> **10.5** There are also consistent reports of excessive fatigue and poor sleep. Fatigue is a common consequence of a head injury of this nature and severity. However, what is unusual in Mr Loughlin's case is that he is not sleeping excessively and he reported to me that he rarely naps during the day.
>
> **10.6** It therefore may be the case that Mr Loughlin's poor organisational skills and lack of initiation results from fatigue which is partly being caused by organic brain damage and poor sleep. I therefore believe that Mr Loughlin may benefit from referral to a specialist sleep disorders unit to see if there are any other treatments available for this difficulty. If his sleep disorder can be treated then it may well be the case that his organisational skills and motivation will improve to some degree.
>
> **10.7** I find it difficult to give a firm prognosis at this stage as rehabilitation only began approximately 1 year ago. Mr Loughlin appears to be engaging in the rehabilitation process at least reasonably well although, to my mind, the goals and objectives of rehabilitation are not clear. I think it would be useful to review treatment plans.

> **10.8** In order to assist the Court at this stage my tentative opinion is that Mr Loughlin will always require some degree of input from a Case Manager and Support Workers.
>
> **10.9** I believe that Mr Loughlin will be able to work at least on a part time basis in routine undemanding jobs. Had it not been for the accident it would appear that he would have had the potential and motivation to obtain a degree and pursue a professional career.
>
> **10.10** I believe that Mr Loughlin realises when he needs to seek advice and from whom to seek it. I think he has sufficient memory abilities in order to retain information he needs to convey to his chosen adviser and retain any advice given. I believe that, if given time, he would be able to weigh information adequately and reach a decision which he is able to convey to his chosen adviser. I therefore believe that Mr Loughlin has capacity to litigate and mange his financial affairs."

28. Dr Moss made further reports, on 21 June 2011, 4 August 2011, 12 August 2012, 27 July 2012, and 2 January 2013 extensively reviewing the relevant care and other records relating to the Claimant's progress, treatment and circumstances. Dr Moss was critical of the efficiency of the rehabilitation work, stating, for example in his report of 4 August 2011:

> "**5.2** In my opinion the rehabilitation team needs to be much more proactive with regard to finding activities for Mr Loughlin to engage in, particularly in the mornings, since it would seem that he has little to get up for. It is therefore unsurprising that he does not get up until late and stays out late into the night/early hours of the morning. In my opinion, this is a common occurrence in people of this age with no regular employment. Presumably, Mr Loughlin was capable of getting up on time in the past since he attended school regularly and attained A levels.
>
> **5.3** It would appear that Mr Lowe, Occupational Therapist with Northern Case Management, has supplied Mr Loughlin with a list of websites and library addresses. In my opinion, there needs to be greater pressure exerted on Mr Loughlin to persuade him to engage in these activities, and ways found to motivate him.
>
> **5.4** At the time of my assessment Mr Loughlin informed me that he had planned to go to university but rehabilitation began and therefore his further education was postponed, although his offer of a university place was still open. It is not clear whether this is still the case. Perhaps this is something that could be explored.

> **5.3** The letter from an unknown author at the Department of Clinical & Health Psychology (whom I believe to be Dr Brown, Clinical Psychologist) would suggest that Mr Loughlin himself is not entirely convinced that the accident has caused the change in personality mentioned by various people and that some of his difficulties are likely to be emotional in origin, particularly in view of his childhood abuse.
>
> **5.4** I am not at all convinced that Mr Loughlin requires care at night. It would appear that when care is provided Mr Loughlin still does as he pleases and at times uses night care staff as a taxi service."

29. After his further review of relevant information in July 2012, Dr Moss concluded:

> "**10.3** The results from this neuropsychological assessment do not reveal any gross cognitive impairments, but bearing in mind the severity of the injury it is likely that there has been some general cognitive blunting and mental slowing.
>
> **10.4** I note that there are consistent reports that Mr Loughlin has difficulties organising and motivating himself. There are also consistent reports of excessive fatigue and poor sleep. Fatigue is a very common consequence of a head injury of this nature and severity. In my initial report I raised the possibility that some of his apparent organisational difficulties may be secondary to poor sleep.
>
> **10.5** Mr Loughlin has been in receipt of a rehabilitation programme for several years involving, at least at times, 24 hour care. He appears to have made little, if any, progress and it is not clear what this programme has achieved.
>
> **10.6** I note that from approximately February 2012 a more rigorous programme was introduced with clearer goals and targets, with detailed guidelines for the support workers as to how these may be achieved. In my opinion, this is the sort of programme that should have been in place from the beginning. As can be seen from the review of documentation above this programme was remarkably successful in a short period of time. Indeed, I have rarely seen anyone respond so well and so rapidly to such a programme. One can only speculate as to how much progress Mr Loughlin would have made if an appropriate rehabilitation programme had been instigated from the outset.
>
> **10.7** I also note that when Mr Loughlin was sleeping at more appropriate times he seems to have been more engaged and compliant with other activities such as personal hygiene and domestic tasks. There also seems to have been an improvement in his general mood state. In my opinion, this indicates that Mr

Loughlin's problems are primarily due to motivation rather than acquired brain damage. If these problems were due primarily to brain damage I would not expect there to have been such a rapid response to the rehabilitation programme. The success of this programme also suggests that Mr Loughlin would respond to a broader and more targeted rehabilitation programme.

10.8 I was informed that when support was withdrawn on Friday and Saturday nights Mr Loughlin's sleep pattern deteriorated. It may be the case that support was withdrawn too early but equally it is not uncommon for young men of this age to have late nights at the weekend. Mr Loughlin himself notes that a significant improvement in his mood and general wellbeing following the introduction of this programme. If use of the internet after midnight is still considered to be a potential problem if night support is withdrawn then, I understand, it is possible to set up the router to block internet access at certain times.

10.9 In my opinion, if Mr Loughlin continues to comply with the routine set up then the likely outcome of this is that Mr Loughlin will develop his own routines and strategies and eventually internalise the structure of programme. This in turn will result in reduced need for support worker input. Currently I do not see the need for a support worker to be present once Mr Loughlin retires to bed until he is awoken the next morning, I can see no reports of any adverse nocturnal events. Further, it would seem that on several nights a week Mr Loughlin is out socializing with friends while his support worker remains at his home. It would also appear that for several hours a day Mr Loughlin is not in the company of his support worker. I therefore do not see the need for 24 hour support worker input.

10.10 I believe that if Mr Loughlin continues to comply with an ongoing structured and targeted programme his stamina levels will increase. On the balance of probability, I believe that Mr Loughlin will be capable of at least part time low level employment if something can be found that interests him.

10.11 I believe that Mr Loughlin realises when he needs to seek advice and from whom to seek such advice. He has sufficient memory and linguistic abilities to convey the nature of his dilemma to his chosen advisor and to understand and retain any advice given. I believe that, if fully supported, he has the abilities to adequately weigh any information provided and reach a decision. He clearly has the abilities to communicate his decision. I therefore believe that, when fully supported, Mr Loughlin has capacity to litigate and manage his financial affairs."

30. In his final report of 2 January 2013, Dr Moss, having reviewed up to date information and reports, maintained his view of the Claimant's mental capacity:

> "I remain of the view that Mr Loughlin has capacity to manage his financial affairs and to litigate. There are references to Mr Loughlin having insight into his vulnerability and taking steps to reduce this. I would agree with comments made that Mr Loughlin may be vulnerable at times of fatigue. However, in many situations this can be compensated for by having formal legal and financial meetings arranged at a time of day when Mr Loughlin is relatively rested and for relatively short periods of time. He could be prevented from impulsive spending by less restrictive means than being under the Court of Protection, such as having money in an account that cannot be readily accessed."

31. In his oral evidence Dr Moss accepted that there was some risk that the Claimant could be exploited, and that the question of capacity in this case was a difficult one.

32. Dr Warburg, a consultant clinical neuropsychologist, made four reports on behalf of the Claimant, dated 3 June 2010, 13 July 2011, 24 August 2012, 11 September 2012. Addressing, in particular, the issue of rehabilitation in his final report, Dr Warburg stated:

> "**8.6** Mr Loughlin continues to perform quite well on tests of executive function, while his day to day difficulties strongly indicate substantial impairments in his ability to structure and organise activities by and for himself. This is not an unusual finding in high IQ adults, who are able to perform well where an external structure is provided, but have great difficulty in providing such a structure for themselves. The nature of neuropsychological testing makes it almost inevitable that an external structure will be provided for the undertaking of tasks, including those tasks considered to fall under the rubric of executive function.
>
> **8.7** Mr Loughlin continues to receive a substantial package of support, which, with the exception of Friday and Saturday nights and Sunday morning, covers the whole 24 hour period. A range of opinion has been expressed on the need for, suitability, and appropriateness of such an extensive provision. Concerns have been raised among others, by Dr Moss and me in our joint statement that the support package lacked focus and goals, tended to provide services to, rather than support for, Mr Loughlin, and risked fostering dependency.
>
> **8.8** In my opinion, these concerns have been substantially and satisfactorily addressed by the rehabilitation team. There is now more structure and goal focus in the team's approach; the sleep programme and fatigue monitoring have helped in the development in a realistic but extended range of activities, and

> the involvement of the occupational psychologist has also supported this. The sleep programme was implemented in February 2012; the formal eight-week is now completed, but the implementation of sleep hygiene measures, outdoor activities, and fatigue monitoring continues. With some lapses, such as those caused by his holiday, I understand Mr Loughlin's adherence to the programme remains good so long as he is prompted to do the necessary things. When support is not there at weekends, he may stay up or oversleep and as a consequence be excessively tired on a Monday.
>
> **8.9** I note that the care experts agree that a period of intensive rehabilitation is needed and also that they have stated that it is "extremely difficult" to predict the longer term needs for support at this point. I agree that it is extremely difficult. At present, Mr Loughlin appears to respond well to prompts to carry out sleep hygiene measures, and he is also more responsive to prompts to carry out domestic tasks or work-related activities than he was at my previous assessment. However, he still relies on externally given prompts, and does not appear to generate them for himself, and certainly not reliably."

33. In that last report Dr Warburg summarised his view of the position generally, including his assessment that the Claimant did not have mental capacity:

> "**9.1** Mr Loughlin has made a good recovery of intellectual function following the impairments sustained as a consequence of his severe head injury in the accident of 28 October 2002. However, very significant cognitive impairments of concentration, working memory, information processing and executive function remain. Mr Loughlin requires prompting, support and structure for everyday activities, without which his lifestyle tends to become chaotic, risky and unproductive. Developments within the rehabilitation team have enabled the rehabilitation to become more structured and goal focused since the last assessment, with benefits to Mr Loughlin's sleeping patterns, structure and range of activities, and to his awareness of the need of structure and strategies to manage his cognitive problems and fatigue.
>
> **9.2** Mr Loughlin will require continued support and input from occupational psychology, clinical psychology and counselling. It is difficult to predict his ultimate support and therapy needs, but a further period of intensive rehabilitation needs to be followed by a period of experimental reduction of support, to establish more clearly which elements of support need to be maintained to ensure maintenance of a structured lifestyle.
>
> **9.3** On the balance of probabilities Mr Loughlin will not be able to obtain and sustain employment in the open market,

> though he may possibly become capable of limited part time work in the future. Fatigue and difficulties structuring his own work are likely to be the main barriers to successful employment.
>
> Mr Loughlin currently lacks the capacity to conduct litigation or to manage his property and affairs. This situation is likely to continue indefinitely."

34. In his oral evidence Dr Warburg enlarged upon the issue of mental capacity, and the following evidence is of some significance:

> "… It might be a situation where he has a girlfriend who says to him, "Look, we could get rid of all your support workers and people that cost you money or you don't like and we can go travelling". That's a decision that he might face. And he might respond in a number of different ways. And all I can do as someone advising the court is to say I think this may happen or that may happen. The critical thing for me is: does his mind present to him alternatives. And I rather think that he doesn't see alternatives in the same way as I do.
>
> …
>
> On the specific question of my differences with Dr Schady, I think – I have been using neuropsychological tests for a very long time. …And I can see the disconnection between doing well on neuropsychological tests and doing well in your life. The literature contains plenty of examples of people in precisely this category. … So the question is: does he have significant levels of executive dysfunction or does he just fall at the end of the spectrum of normal untidiness and disorganisation? … There are very many indicators – and I think it is agreed that he has at least some degree of executive dysfunction. Right from the very beginning we have indications of frontal lobe damage and many experts are saying he has executive dysfunction. So I don't think there's any doubt that that is present. … The question then, for me, becomes, in trying to advise the court on capacity: is the level of executive difficulty so great that he really cannot consider the – he cannot formulate the problem he has, he cannot consider the alternatives, he cannot come to a reasoned decision? … These examples show us that he gets into a mess. … The university example shows us, I think, to quite a remarkable extent, that he doesn't pursue – he is unable to pursue things that you might reasonably expect him to pursue. … He wants to go to university but he can't actually do the paperwork; he can't make the arrangements. He wants to go to RIFFs to do his music lessons, but he cannot bring himself to make a phone call because he can't envisage what's going to happen when he makes the phone call. You're saying there –

> Q: And you're saying this is quite intense and frequent in his case?
>
> A: Yes, I think this is more than just the normal disorganisation or inefficiency of a 22 year old. … This has definitely got added executive dysfunction.
>
> To me, the worst problem that he has got is not so much that he can't make the decision once the information is presented to him, although he has difficulties there, but he's not aware that he has a problem that he needs to solve. … So he's not aware that he needs to do the university completion. And I think that, looking to the future, he's going to have great difficulty. Should he be in charge of a large amount of money, he's going to have great difficulty formulating the problem that he has, because the problem that he has is something to do with making this last. He has asked his deputy whether he can spend the first bit on holidays. … I think it's to encompass all the decisions he has to make and also to be aware of what the consequences are of failing to make a decision. That's where I think he stands out even from ordinary disorganisation. But it is a judgment at the end of the day."

35. Dr Kieran O'Driscoll, a consultant neuropsychiatrist, also made two reports on behalf of the Claimant, dated 13 August 2010 and 16 September 2012. In both reports Dr O'Driscoll concluded that the Claimant lacked capacity, summarising the matter in his second report as follows:

> "**1.** It is now ten years since Mr Loughlin suffered a severe traumatic brain injury. He continues to have difficulties with his cognitive behavioural and emotional domains.
>
> **2.** His cognitive difficulties are consistent with a dysexecutive syndrome manifest by poor organisation and planning and difficulty sustaining attention. This will be consistent with a frontal lobe brain injury.
>
> **3.** His behaviour difficulties are consistent with Organic Personality Disorder manifest as impulsivity, disinhibition, poor judgment and lack of motivation. This would be consistent with frontal lobe brain injury.
>
> **4.** His emotional difficulties are consistent with either an Organic Personality Disorder or an Adjustment Disorder secondary to the affects on his lifestyle from his traumatic brain injury. Mr Loughlin has sufficient insight to recognise the impact of his disabilities and his quality of life from which he suffers a reduction in mood.
>
> **5.** It is evident that despite intensive brain injury rehabilitation Mr Loughlin had not been able to achieve independence and

> continues to depend on support to organise, motivate, monitor and adjust his daily living activities. Mr Loughlin has made some gains in his level of daily function but quickly decompensates when support is removed. This would be consistent with the affects of frontal lobe brain damage. In my opinion there is evidence to justify the need for support during waking hours seven days a week. The need for night time support could be adjusted over time but previous experience has shown that Mr Loughlin can be taken advantage of and would need to be protected from night callers. I appreciate Mr Loughlin's desire for some freedom at weekends but given the need for a strict daily routine as a therapeutic optimum I would not recommend varying this routine for any day of the week.
>
> Mr Loughlin in my opinion does not have capacity to manage his financial affairs as he lacks judgement and can act impulsively without appreciating the consequences. He is in my opinion a protected party within the meaning of the Mental Capacity Act 2005.
>
> In my opinion I do not believe Mr Loughlin is employable in the open market. I do believe he would benefit from vocational activities such as charity work to enhance his self esteem."

36. Dr O'Driscoll is a consultant neuropsychiatrist with considerable experience, both in community based rehabilitation and in the clinical tertiary setting. He emphasised that neuropsychiatrists focussed mainly on the behavioural and emotional aspects of frontal lobe injury. The following parts of his oral evidence are of particular significance:

> "It is recognised that injuries at an earlier age have more profound consequences. The reason for that is because the frontal lobes are very important in acquiring social rules of engagement and subtleties and sophistications of interpersonal relationships. And, therefore, if an individual suffers an injury to the part of the brain, in crude terms the organ that is so important for acquiring this skill, they're at a significant disadvantage from an adult who suffers the injury having already acquired those skills, because they have at least had the experience of using those skills which they have lost; whereas the younger individual has never acquired them in the first place.
>
> I think the particular difficulty he has in weighing up the consequences of his decision. From reading Mr Loughlin's behaviour, he appears to be very much in the present. He operates in the present tense. And he doesn't seem to be able to anticipate the consequences of his actions either at a behavioural or an emotional level. Therefore I think that he's very much disadvantaged in terms of his decision-making processes as to what the short, medium or, certainly, long term

> consequences of his decision would be. The other problem is – and it goes back to the emotional aspect – the way the Mental Capacity Act is constructed gives the impression that the cognitive or intellectual side of things is the most important, in terms of language, memory and rationalising your decision. But, in fact, emotion plays a very powerful part in our decision-making. And my impression is that Mr Loughlin's emotional understanding of the world and people has been impaired. For example, he has been described as staring at people inadvertently. And he got his jaw broken in town. We don't know the exact details but the suggestion is that he wasn't quite reading the emotional cues of his potential assailant. And that with his girlfriends there also appears to be – observed from his carers – a difficulty in understanding them emotionally and predicting the way that the relationship is going. I think at an emotional level as well he would be impaired in terms of being able to anticipate the consequence of his actions.
>
> One of the problems in the real world – in what might be called the laboratory setting or the consulting rooms, it is very much an artificial environment. Therefore if you ask an individual how they would behave, for example, were they to receive money and they tell you that they would invest it in a house, you really have to take that into context of the rest of the observed behaviours in the real world, because it is very well recognised that folk with frontal lobe brain injuries say one thing and do another. And its the unpredictability of the real world that renders them vulnerable. So with all the best intentions he may have wished to do something, but in certain circumstances, given unpredictable conditions, he could easily do the opposite. And that's my concern, that he would be vulnerable in an unpredicted and unmanaged environment.
>
> Well, taking the bigger picture into account – and we've talked about the emotional and the cognitive side of things and the behaviour – I think taking the whole picture into account, I would have to fall on the side that he doesn't have capacity.
>
> I think its finely balanced, but from the start I think I had – put it this way: I've seen finer balanced – in other words, I think that I was more comfortable in saying that he lacked capacity in this situation than I have been in others."

37. Dr O'Driscoll did not accept that the Claimant would seek advice from his case manager:

> "I'm struggling with that one, because my concern is that Kristopher – and, again, it's the nature of the injury that he has to know when advice is appropriate – when it's appropriate to seek advice. And my concern is that he may not know that it's

> – that he needs that advice, because he needs the insight to know that.
>
> …
>
> That's not the impression I get from the monthly records, particularly of Ms Gibson. The impression I get is that he's a man who needs prompting and supervision; and that he doesn't appear to know when he needs to know. In other words, that they seem to have to make that judgment for him and advise him in an unsolicited way."

38. Professor Michael Barnes, Professor of Neurological Rehabilitation, also made expert reports and gave oral evidence on behalf of the Claimant. I very much regret to say that I am unable properly to take that evidence into account. I shall not disturb the flow of this judgment by stating why I had to reach that conclusion, but my reasons are set out in a separate Annex to the judgment.

39. A number of lay witnesses, who had been involved in the life of the Claimant in various roles, expressed concern about this mental capacity to manage his affairs. The following oral evidence is significant in that respect:

Barbara Kennedy (the Claimant's mother)

> "While Kristopher can manage very small sums of money he could not manage the day to day responsibility associated with running a household or a large sum of money.
>
> Kristopher is not able to manage his finances and would need considerable help and support to plan and organise this together with his daily life.
>
> He is vulnerable to exploitation as he is naïve and trusting. Recently he was approached by a member of the church for scientology and invited to an appointment at which he was due to attend. The only reason he did not attend is that he forgot the appointment. He takes everything at face value and does not question or enquire about their probity.
>
> He certainly could not pay his bills without significant help.
>
> I do not believe that Kristopher has the capacity to manage his own financial affairs, certainly not at the moment, whether that will change in the future only time will tell as Kristopher matures further. He can handle small sums of money but not larger sums and I think he will always need some form of support to handle his money."

Claire Stepsys (the sister of the Claimant, now aged 31)

> "It is impossible for him to make a decision and sometimes my mum and I both just make these for him.

> I do think that if Kristopher was given a lot of money he would either blow it all on something stupid or forget he had it.
>
> … recently Kristopher's computer stopped working, yet it took him four days to tell his mum because he kept forgetting.
>
> Since the accident Kristopher only sees things in black and white and has rigid thinking."

Yvonne Ashworth (support worker since September 2009, employed by Northern Case Management Limited)

> "I do not believe that Kris has the capacity to manage his own litigation. He is unable to sit through any meetings without becoming distracted and losing concentration, and is simply unable to understand the legal process. The only thing that he keeps asking is when the case will finish. He is also passive and seems to not really care about things at times, and I therefore think that he would easily just go along with whatever was suggested to him."

Beverley Wild (case manager since 17 November 2008, employed by Northern Case Management Limited)

> "… Kristopher presents very well when you initially meet him. And it was only through experience of Kristopher and some of the problems that arose that I then doubted his capacity to manage finances.
>
> Because at that time he was living in an apartment and we were trying to look at his budgeting skills. So he [the word should be 'we'] had actually set a plan for him to save in order to buy the drum kit. And then he went out and purchased it without the saving, because at that point, mum had his benefits. So he got his disability living allowance and purchased it. And we'd actually got a plan in place. And I had actually had conversations with Kris about it not being appropriate having a drum kit in an apartment where you have people living around you.
>
> Because Kristopher will buy things quite impulsively without thinking about the rest of the month he has to have that money for in order to buy food.
>
> … Kristopher had also bought a guitar around that same period of time, which cost £220, and he just went out and bought it and, again, left himself with no money."

The Defendant's Submissions Regarding Mental Capacity

40. The Defendant's case may be summarised as follows:

41. The Claimant has been exposed to few situations of challenge that might enable the court to conclude that he had displaced the legal presumption that he had mental capacity. Even if the Claimant had made (relatively small-scale) imprudent purchases, a person is not to be treated as unable to make a decision merely because he makes an unwise decision. There was in this case no controlled attempt to assess whether the Claimant would be competent to manage larger sums. No trial of access to larger sums has been attempted as was suggested by Dr Moss. However, the Claimant has not run up debts. He has not used the internet, with which he is fully familiar, to purchase goods or services or to gamble. On the single occasion on which he attended at a bank, there was no preparation for this event or any early intervention to have matters explained to him in short sentences.

42. As to initiative and motivation, the Claimant in January 2008 applied for part-time employment at Peacocks. He had no support worker, case manager or occupational psychologist at that time. The Claimant held down his job for four hours per week, even if he had a sympathetic employer. His activities included football, travelling and socialising. More recently, he has engaged with the sleep hygiene programme and the activities planned with him. When given responsibility for his own actions, he has demonstrated sufficiently that he can be relied on to act. He has never made any concerted effort to dispense with the services of his solicitor, deputy, case manager or support workers or expressed a wish that he could do so. At most, he has expressed frustration with the intensity of the support worker regime. He has often sought their advice, and he has some insight into his need for their continued support. It was submitted that the Claimant would retain their services if the decision were his alone in the future.

43. There was no evidence of the Claimant failing to seek appropriate advice in relation to a significant decision in relation to his property and affairs or of failing to heed it, weigh it and come to a reasonably balanced decision. In relation to the selection of a suitable flat the Claimant did accept advice.

44. It was also pointed out that the Claimant has been surrounded from the outset by persons who have concluded that he is unable to make decisions for himself. From an early stage the Claimant has had no autonomy of access to his own funds. No real attempt has been made over three years to assess how reliable he is with more then £50 twice per week. Even with this case pending for trial, no attempt has been made to re-assess his reliability following the inception of the sleep hygiene programme and his positive engagement with ideas suggested to him.

Discussion

45. Each of the experts said that the issue of mental capacity in this case is very difficult and finely balanced. Having heard all the evidence I agree. One difficulty in particular was this. In respect of executive capacity and the ability to manage his affairs, it was intrinsically difficult to separate conduct and patterns of behaviour, that might bear upon the relevant assessment, that were wholly or mainly attributable to psychological explanation rather than wholly or mainly attributable to the organic brain injury. In simple terms many young men, who suffer no brain injury at all, are indolent, unmotivated and prone to make financial, and other, decisions that are unwise or even calamitous.

46. In this context, the Defendant contended that psychological factors including "learned helplessness" substantially contribute to the Claimant's difficulties and indeed largely govern his conduct. He has become so used to others, well-meaning in their approach, intervening to do things for him that he lacks the motivation to do things for himself and has become accustomed to their early intervention on his behalf.

47. The Claimant appeared motivated to do things that interest him, and is willing to engage when incentives are placed before him. He had made substantial and rapid progress over a very short timescale in complying with the sleep hygiene programme.

48. He sustained his job at Peacocks for three years. He was motivated to attend College to do his A levels. He had been motivated to go to see his girlfriend in Brighton. On the first occasion he went by coach and was observed to book all his tickets correctly online. He then travelled to London and then on to Brighton by coach and returned at the end of the weekend as planned. He kept in appropriate contact with his support worker by text. On two further occasions in November 2010 and March 2011 the Claimant travelled by train to London Euston, then by the Underground from London Euston to London Bridge where he found and boarded the train to Brighton. At the end of each weekend he made the return journey.

49. It has been suggested that he does not sustain friendships. This issue was first explored during the cross-examination of Dr Moss. It was not raised by the case manager. It would be surprising if it was accurate because the Claimant has played football on a regular basis since the case manager became involved. Presumably he plays with the same people. He seems to have ready access to persons with whom he socialises.

50. The Defendant submitted that the evidence indicated that the Claimant had made very considerable progress and is indeed internalising and understanding the need for a sleep pattern and to rise for morning activities. The sleep record and prompt sheets for September and October 2012 as compared with February and March 2012 record fewer prompts and less daytime tiredness. As Dr Moss stated in evidence, it might take some years finally to embed the understanding in the Claimant about the sleep regime. It was reasonable to expect that this would happen in the foreseeable future.

51. I see considerable force in the foregoing points made by the Defendant. However, with respect to the powerful presentation by Mr David Heaton QC on the Defendant's behalf, many of the points cut in both directions. For example, it is correct that the Claimant, apart from some small and relatively unimportant purchases, has been quite responsible in his money affairs, not, for example, incurring debt. However, the fact is that in this aspect of his life he has been kept on a tight and disciplined rein, and there is, in my view, a concerning uncertainty as to his capacity to manage, without any such constraint, a very large fund in the future. I am then compelled to consider the picture more broadly. The experts, as I have explained, were divided, agreeing, however, that this was a very difficult case to assess with any confidence. Each expert had prepared detailed reports and had formed his opinion on the basis of a large volume of information. I was impressed by the expertise of each of them and by the care that each had taken in reaching his conclusions. However, I was most favourably impressed by Dr O' Driscoll. Not only did he have expertise that comprehensively embraced all the issues as regards capacity, he had also considerable practical experience in working with cases, such as the present one, which were at the

margin between capacity and incapacity. He had before him all the information, gathered over many years, about the Claimant's behaviour, and the assessments made by others. He accepted, in line with the expert evidence on behalf of the Defendant, that, so long as the Claimant had the capacity to recognise that he needed appropriate guidance and assistance, and the capacity to take and act upon such advice and assistance, the Claimant could be treated as having capacity in the legal sense. However, unlike Dr Schady and Dr Moss, he did not believe, having regard to the information that he had taken into account, and to his experience in similar cases at the margin, that the Claimant had the capacity to respond in the appropriate manner. I had been troubled, during the course of the expert evidence, by the real possibility that such deficiency – to use a neutral expression – arose from psychological factors, independent of the damage to the mental functioning occasioned by the accident. However, the best judgment of Dr O'Driscoll was that that was not likely to be the case when due consideration was given to the Claimant's life history as a whole, and the noticeable changes in behaviour after he had sustained his injury.

52. Furthermore, I believe that this is a case, perhaps somewhat exceptional because of its marginal dimension, where I should take into account the views of those professionals who have had close and frequent contact with the Claimant (see paragraph 39 above). None of them believes that the Claimant has capacity to manage his affairs. Mr Heaton QC again questioned them vigorously as to the basis of their opinions, and suggested that there was insufficient hard evidence, in the form of specific events or transactions, to support them, and that there were examples of the Claimant, when sufficiently motivated and interested, managing independently and satisfactorily. However, I have to bear in mind that those working in close and frequent contact with the Claimant are likely to have a "feel" for his capacity to manage his affairs, if he were in a position to act independently and were free of the level of supervision to which he has been, and continues to be, subject.

53. Therefore, I conclude, notwithstanding the legal presumption in favour of capacity, that the Claimant does not have capacity within the relevant legal definition.

Past Professional Care/Case Management

54. This was the second major issue of fact at the trial. The evidence showed:

i) In her case management plan dated 31 December 2008, Ms Wild noted that the Claimant "…has no regular routine for rising & retiring to bed…". She did not record any specific plan to deal with this. She made no referral to a neuropsychologist until August 2009 and her letter of referral did not ask him to address this specific issue. The Claimant did not see Dr Perry Small until 2 September 2009.

ii) In his note date 16 April 2009, David Lowe, the in-house occupational therapist from Northern Case Management, noted that he had "expressed the importance of having a good sleep routine and pattern and it would be useful for him to rise and go to bed at similar times. DL explained that it is good to keep active which Kristopher is currently doing…DL explained that he will now go away and formulate a plan". No sleep programme was drawn up until May 2010.

iii) In her case management plan dated 24 August 2009, Ms Wild noted that the Claimant "…has no regular routine for rising & retiring to bed…", that he "…will rise late morning if he has nothing planned in for the day…" and that he "…does struggle to wake in the morning". However, she made no specific plan.

iv) In her case management plan dated 25 September 2009 Ms Wild repeated what the Claimant had told her about his absence of sleeping routine. She noted that he had seen Dr Perry Small but there was no reference to any strategy or the seeking of any advice for this problem.

v) In her case management plan dated 18 February 2010, Ms Wild again noted that the Claimant had no regular routine for rising and retiring to bed. She also notes that the support worker "…has developed a routine whereby she texts him to let him know she is on her way and for him to get up. There has been some success with this although there have still been times where Kristopher has still been in bed when he arrives. Kristopher has on a number of occasions only got home at 6am when out with friends even if appointments or activities are booked for that day. This invariably means that he will be falling asleep throughout the day and is not motivated to do anything". However, no sleep programme was formulated.

vi) In April or May 2010 a sleep programme was written up. The programme, however, did not identify a rising time or morning activity of interest to the Claimant. It did not state that it has been put to him and that he had agreed to engage in it. On 10 May 2010 it was noted that the implementation of the sleep hygiene programme had not been achieved.

vii) The care regime was then reduced at night even though a sleep routine had not been established. The Claimant's life fell into disorder and night cover had to be re-instated.

viii) The Claimant's sleep routine remained unaddressed throughout 2010 and 2011. An appointment was finally made in September 2011 for the Claimant to see Dr Cooper on 24 October 2011.

ix) Furthermore in their joint statement dated 16 September 2011 Drs Warburg and Moss were critical of the case management of the care regime, expressing concern that "…the goals of the support package are not as clearly specified or challenging as they need to be and that there is evidence that support sometimes takes the form of provision of services such as transport or carrying out domestic tasks without Mr Loughlin's participation. We agree that to the extent to which this occurs, this is not an appropriate use of support and will tend to foster dependence rather than independence".

Discussion

55. There is, in my view, very considerable force in the Defendant's criticisms of the care package. However, I have to be sensitive to the fact that the care workers were having to support a young man with a serious brain injury, that the implementation of

a sleep hygiene regime (at least early on) would have been far from straightforward, and that it is all too easy to be critical in this sphere with the benefit of hindsight.

56. I accept the evidence of Ms Wild that implementation of a disciplined sleep regime would have posed insuperable difficulties at the time that the Claimant was living with his mother and before he moved to his own accommodation. His mother at that time was his primary carer, with limited professional support, and understandably she did not perceive such a regime to be an indispensable aspect of rehabilitation, particularly given that the Claimant faced other challenges, for example, his "A level" studies. The care team were focused on helping the Claimant adjust his life and in seeking to engage him actively in meaningful activities and pursuits.

57. I have no doubt that by the time he left his mother's home the irregular sleep pattern (basically, going to bed far too late and then rising after most, if not all, the morning had passed) was having a significant detrimental effect on his rehabilitation, and that this fact was known, or ought to have been known, to competent professional care workers. However, inadequate steps were taken, first, to establish a specific regime, and to seek to implement such a regime. The tenor of the evidence was that the Claimant resisted efforts to impose discipline, and that greater efforts would inevitably have failed. I am not convinced.

58. The Claimant makes the point that Jill Ferrie (the Defendant's care and case management expert) did not mention a sleep hygiene programme in her reports of May 2010 or April 2011, and Dr Schady did not specifically recommend referral to a sleep hygiene specialist until July 2011. However, this issue received intense scrutiny at the trial, and I have to form my own objective view. I also take account of the evidence, given by Ms Wild, for example, that there was a need to maintain a balance between intervention and promoting a good relationship with the client.

59. Ms Wild's evidence was supported by Maggie Sargent. She has had great experience over 30 years in the care of patients both in hospitals and in the community, and is a director of a national care consultancy, which offers care management services for persons with severe disability. In her evidence she said:

> "The only thing I will say, as a practising case manager, 18-year olds are very difficult to get to engage. …I have huge experience of this group. I have a lot of people we still case manage now, they're young adults, we've worked with them since children, over a 20 year span. And they can be a nightmare at 18. They're sort of trying to push boundaries. They don't want to accept. It can take us years. I do think it is very difficult, within the court system, sometimes that we try to put people at an age to go and live in their own accommodation or trial independent living, long before we would normally. And it is just one of the occupational hazards that we have that we get particularly asked to bring people. It is jolly difficult. It is very easy to say. I can write these reports. I can tell my case managers, "Why haven't you done it?" Because I check and we go through all their cases. But what do you do when they won't engage and you have an 18-year old who really does lack the ability to be able to see the importance of it, which is why

> I've said here the neuropsychology was necessary. He had to engage with that."

60. However, in this case the contemporary documentary evidence did not show, first, that the care team recognised, until the problem had become chronic and practically overwhelming, the fundamental importance of addressing the need for a specific and effective sleep hygiene regime, and secondly, that the team took determined steps to implement such a regime, a task that I readily acknowledge would have encountered resistance and would have required skilful and tactful management.

61. I also recognise, from the evidence, again principally, Ms Wild, that the combination of circumstances in 2012 made it easier to formulate and, especially, to implement a sleep hygiene regime. I do not assume, however, from the mere fact of success in 2012 that an earlier determined attempt would have succeeded. I am concerned, as explained, that notwithstanding the more difficult circumstances before 2012, the efforts made on this fundamental aspect of rehabilitation were simply not adequate.

62. Given such a finding of fact on this issue, the Defendant's primary submission is that I should disallow the costs of past care and management, on the basis that the standard of such care and management fell significantly below that which could reasonably be expected to meet the exigencies of the Claimant's condition and circumstances. Mr Heaton QC relied on *O'Brien v Harris* (22 February 2001 unreported). However, I agree with Mr David Allan QC, on behalf of the Claimant, that such a result would operate with undue harshness on a successful Claimant, who had had to receive, and pay for, as a result of the Defendant's wrongdoing, care and case management services, and who had had in fact very substantial benefit from such services. To deprive a Claimant of all compensation for incurring such costs, whatever the shortcoming in their delivery and whatever the benefit received, would be wholly disproportionate and unjust. However, it does seem to me that principle requires that I should take due account of the fact, that I have found, that the standard of the care and case management services did, in an important respect, fall significantly below the standard that could reasonably have been expected. In other words, the objective value of what the Claimant received was less than the amount of the charges made for the relevant services. There is no precise means of quantifying the appropriate reduction: the exercise requires the court to take a broad view of what the Claimant did receive, and the nature and extent of the putative shortcoming, bearing in mind the particular difficulties in the case, to which I have already referred. It appears to me, balancing these factors, that a reduction of 20 per cent in the charges actually claimed would be fair and proportionate.

Future Care/Case Management

63. It is clear that without continued support the Claimant will not be able to manage on his own. The experts agree on this. The issue between the parties is the extent of such care. The Claimant's case is that he needs, and is likely to continue to need, eight hours of care in the day and a sleep-in carer at night. The Defendant's case is that it should be possible to reduce the care regime in stages over the next three years so that continuing support of two hours in the day, and no night care, would be sufficient.

64. The resolution of this issue turned largely upon the extent to which the Claimant could reasonably be expected to "internalise" his current regime of a relatively disciplined sleep programme and enjoying daytime activities, without the intense level of support that he currently receives.

65. The Defendant submitted that, with the well-structured rehabilitation approach now being pursued, both in relation to sleep hygiene and the activities programme, the Claimant needs to be able to internalise the current prompts and to develop his own systems to support his memory and motivation. The expectation in the joint report of Dr Warburg and Dr Moss was that his care needs should reduce. The recent support worker records suggested that fatigue was less of a prominent issue; provided that the Claimant has a rest, he can go out, as he often does, in the evening to socialise. Even after the weekend when he has no overnight support on Fridays or Saturdays, he does his weekly activities as usual. The same applies even when during the week his new girlfriend, Hannah, stays over. The process of internalisation, including an understanding of the purposes and benefits of adherence, is well under way; the Claimant now comes home earlier, often unprompted before 10pm.

66. The Claimant may well also be unwilling to tolerate such an intensive care regime. The recent records show that he cancelled his new support worker Mark McGuire on 24 November, 2012 and 25 November, 2012 when he was due to support the Claimant.

67. In the circumstances, it was much more likely that the Claimant would make progress in his routine and habits and require in the future less care. Provided that the care was reduced gradually and a contingency for crises was allowed, the Claimant would be able to enjoy a good quality of life in the future.

Discussion

68. Again I have found this a difficult issue. It was plain, before the present regime was put in place, that the Claimant's unstructured lifestyle was a fundamental impediment to progress. In short, he was not going to sleep at a normal hour, tending to use his mobile phone and computer until the early hours; he did not get up at an acceptable time, and then did not engage in activities that motivated him. That has now been addressed. Nonetheless the Claimant continues to receive "prompts" – to put away mobile phone and computer at a reasonable time, to rise at a sensible hour and to engage with activities, particularly outside the home.

69. Ms Wild in her evidence said that without the "prompts" the Claimant's life would again become unstructured and undisciplined, not allowing him to enjoy a quality of living that he might otherwise experience and that was closer to what was expected before his injury. Dr Moss was more optimistic and believed that within 3-5 years the Claimant would be able to "internalise" prompts so that his need for support would be reduced. Dr Moss accepted that if the prompts did not become "internalised" the Claimant would need support.

70. I accept from this evidence that the ability of the Claimant fully to "internalise" the need for a structured, and therefore, higher quality lifestyle is restricted by reason of his injury and very considerably less than the capacity of a person of his age and character who had no such injury. I also accept that this reduced ability requires

continuing support to ensure that sufficient "prompting" is in place so that the Claimant does not fall back into the kind of undisciplined regime that prevailed for some time. The crucial question is the level of support that is reasonably required.

71. It must be remembered that a determined effort to address the problem of the Claimant's lifestyle was made only relatively recently. When an efficient programme was put in place, the Claimant responded with remarkable success and that achievement has been maintained. Fatigue does remain an issue, but the evidence strongly suggests that it has receded to the extent that the Claimant is engaged in activities and pursuits that he finds interesting and stimulating. Provided that he has sufficient periods of rest, he is able to socialise in the evening and to engage in interesting daytime activities. He has no overnight support on Fridays or Saturdays, but this does not appear to undermine his ability to revert to his weekday programme after the weekend. Similarly when his girlfriend, Hannah, has stayed overnight during the week, he has been able to resume his usual programme the following day.

72. Furthermore, it seems to me very doubtful whether the Claimant himself would be prepared to tolerate an intensive support regime well into the future. That was an issue raised some time ago. There is evidence that the Claimant has already on occasion taken steps to cancel his support, when he has thought that such support would be unduly intrusive and unnecessary, without significantly affecting the stability of his life. He remains relatively young at the moment but, from what I have heard, it seems to me that, as he became older, this problem would be likely to increase.

73. In these circumstances the precise level of necessary support is not easy to specify. A certain degree of "prompting" will remain imperative, and, in my view, early morning is for the Claimant an important time: he is likely to continue to require "prompts" to ensure that he gets up at a reasonable time, and continuing "prompts" to ensure that he then engages in activities that are interesting and stimulating, particularly outside the home. It seems to me that relatively intense and focussed support in the mornings would be likely over time to be sufficient to inculcate, through habituation and a limited degree of "internalising", the need for a regular sleep pattern. I am not persuaded that a continuing care package of eight hours full time support during the day and a "sleep-in" case worker is reasonably necessary to achieve these objectives. There is a very serious risk also that such a package would leave the case workers largely unoccupied for substantial periods and the Claimant, as has happened in the past, could come to see them as useful service providers in a broader and wholly inappropriate manner.

74. In the longer term I believe, therefore, that support of four hours a day, focussed on the morning period, with an emergency back-up facility overnight is reasonably required in this case. However, I accept that such a reduced programme of support needs to be phased in carefully. The Claimant has been accustomed to a very intense level of support for a substantial time, and both he and those providing support require a reasonable period for implementation of a reduced regime. The Defendant has suggested a period of three years, but I am concerned, given the preceding history, that that might put unacceptable pressure on all concerned. It is perhaps to err on the side of caution, but I believe that the prudent course would be to allow the proposed reduced support to be phased in over a period of four years. I also believe that in the first instance the parties should seek to agree the precise details of how such a

programme could most fairly and effectively be implemented over the next four years, and also to seek to agree the costs of continuing care and case management in the light of this judgment. If the parties cannot agree on either or both of those issues, I shall of course resolve the dispute.

Past Gratuitous Care

75. In the Updated Schedule and Counter Schedule, the Claimant claims £110,058.13 for past gratuitous care; the Defendant accepts liability for £26,057. The Claimant did not allow any discount for the fact that care was provided gratuitously. That has now been agreed at 25 per cent, so that the difference between the parties has also narrowed.

76. It is clear that the Claimant's mother (Barbara Kennedy) has had to spend a great deal of time encouraging, motivating and cajoling the Claimant. The extent of the demands on the Claimant's mother were much greater than could reasonably have been attributable to the normal care provided to a child or adolescent.

77. Following the accident Mrs Kennedy took a leave of absence from work but was then compelled to leave her job. She remained at the hospital for the four weeks that the Claimant was there. After the Claimant was discharged on 23 November 2002, Mrs Kennedy stayed at home to take care of him, which she did full time until he returned part time to school in February 2003. In her statement she described her responsibilities:

> "Initially I had to do everything for him, get him up, dress him, brush his teeth, get him downstairs, get him to the toilet, help him to have a bath because one of his legs was pinned and plated. I had to take him to hospital appointments, and he was in a lot of pain. To make matters worse Kristopher was not sleeping and this impacted badly on him, and in turn me. It was a very difficult and long period of recuperation. Even when he progressed to crutches, he could not carry anything so I had to follow him with a drink or a sandwich and be on hand to help him."

78. After the Claimant returned to school he continued to require substantial support form Mrs Kennedy. She took him to school in his wheelchair and then waited until he was ready to return home two hours later. She referred to his fatigue and to the difficulties she faced trying to get the Claimant up in the morning. Mrs Kennedy returned to part-time work in September 2003. Her responsibilities for the Claimant included basic food preparation, washing, ironing, taking him to hospital appointments, sorting out prescriptions and activities.

79. The Claimant relied upon the expert report of Maggie Sargent. Maggie Sargent provided an estimate of the past gratuitous care costs in her first report, dated June 2009 but based on a visit in January 2009. She had visited the Claimant and his mother at the family home while he was still living there. She spoke to Mrs Kennedy but also reviewed the medical records, school records, hospital records, GP records and witness statements. Her estimate took into account the hours of care that would

have been provided to the Claimant by his mother if he had not been injured. Her general approach was indicated in her oral evidence as follows:

> "It's not a precise science. The sort of care he's had isn't helping him to get in and out of the bath or easily quantifiable. It has been support – it has been on call support that she was providing. And that's why I've taken a view on it. And there is, in my experience, in this sort of injury no other way of doing it. You cannot precisely say it is an hour a day for prompting or whatever because you're actually providing that support at different times of the day and night. So that's really the view I've taken. Obviously it was very intense in the early stages with a lot of night care."

80. The Defendant relied upon the expert report of Ms Jill Ferrie and, on the basis of that report, made specific criticisms of the Claimant's estimate of cost of gratuitous care. For example, the Defendant submitted that, notwithstanding the matters referred to Ms Sargent, twelve hours a day of gratuitous care when the Claimant was in hospital was excessive, given the periods when medical and nursing staff was present and when Mrs Kennedy was likely to have been taking breaks. Ms Ferrie assessed six hours a day as a reasonable estimate. In the following period it was submitted that eight hours per day during school holidays, and thirty hours per week when the Claimant was at school were also excessive. Mrs Kennedy provided a diary, and it was submitted that this did not show a level of care substantially above what would have ordinarily been provided by a mother to a son of the Claimant's age. Ms Ferrie had adopted a task-based approach to quantification which was put forward as a sounder basis for calculation.

81. I see force in these criticisms, but also accept Ms Sargent's basic point that this is not a scientific exercise readily amenable to the kind of specific and detailed approach adopted by Ms Ferrie. It does seem to me nonetheless for the reasons given by the Defendant that the number of hours of gratuitous care, both in hospital and at home, are likely to be somewhat overstated and, in fairness, ought to be reduced. In my view, it would not be sensible to seek to produce a detailed breakdown and that a broad approach to this issue is appropriate. I would reduce the figure for past gratuitous care to £60,000, which also allows for the 25 per cent discount as previously explained.

Loss of Earnings

82. The evidence, in my view, supports the Claimant's case that, if he had not been injured, he would, on a balance of probabilities, have gone to university, graduated and obtained graduate employment. The Claimant claims that, as a graduate, reasonable yearly average net earnings of £30,000 until an assumed retirement age of 70 is a reasonable basis for calculating lost future earnings.

83. I would take a slightly lower figure for the following reasons. According to figures released by the Higher Education Statistics Agency (HESA), the median salary for full-time graduates for 2010/2011 whose destinations were known and who were in full-time employment in the UK six months after graduating was £20,000. The association of Graduate Recruiters (AGR) produced a survey in 2009. The median

salary for graduates in 2009 was £25,000, based on data for salaries paid to new employees. In 2012, research by AGR showed that starting salaries had increased to £26,500.

84. In these circumstances it is reasonable to assume that as a graduate in 2012, the Claimant would have earned about £26,000 gross, corresponding to a net salary of about £20,000. Average gross earnings in April 2011 were £34,221, with a net equivalent in 2012/2013 of £26,449. In present economic conditions it is far from clear that the net earnings of the Claimant, even as a graduate, would in the future have risen significantly above that figure. However, the possibility cannot be ruled out that they might have done so, particularly if, as could reasonably be expected, economic conditions change favourably at some point in the future. Again a precise calculation is not feasible, but, looking at the matter in the round, and taking account of the considerable uncertainties inherent in this topic, it appears to me that net average yearly income of £26,000 could reasonably be taken. I see no justification for altering the present expectation of those entering the employment market that pension age will be 68. The appropriate total multiplier for future loss of earnings to age 68 is agreed at 24.6, and the assessment of future loss of earnings is £26,000 x 24.6 = £639,000 I have not specifically deducted any amount for the value of tuition fees to be repaid (£9,000) or for travel expenses (the Defendant assumes £56,721), because, as explained above, the figure of £26,000 is a broad and, on one possible view, conservative assessment of average annual net lifetime earnings, allowing for the ordinary expenses of employment.

85. The Claimant's residual earning capacity was a contentious issue at the trial. The Defendant contended that the Claimant was capable of doing low paid part-time work, three days a week, four hours a day for 48 weeks a year. His gross (and net) income would, therefore, be £3,565, and, after other deductions, and on the appropriate multiplier, the net lifetime earnings would be about £36,000, an amount that, therefore, should be offset against the figure of £639,000 above.

86. On this issue I attach considerable weight to the evidence of Gwendy Gibson. Since September 2011 she has seen the Claimant on a regular basis, initially weekly but more recently once every fortnight or three weeks.

87. In her oral evidence she made the following observations about the Claimant's capacity for paid work in the employment market:

> "My observations and my experience tells me that there are kind of key indicators that I would look for in a client to indicate employability. My observations regarding Kris – and, I mean, I draw them from my observations of him in the work placement environment – if Kris isn't able to attend a placement, does he phone to cancel the placement? No, he doesn't. He doesn't initiate that because he can't initiate that. If he's prompted to phone the placement to say he can't come, sometimes he does it, sometimes he doesn't.
>
> The times he doesn't do it he has perhaps been asked when he's eating breakfast, texting, and he doesn't follow through with it.

> When he's in the placement – I mean, one of the examples that when I was in placement I've observed Kris struggling with a variety of things. And you can tell from my report we implemented some compensatory management systems within the radio placement to help Kris cope.
>
> I guess over a six month period my observations have been that Kris is not independently using those systems. He needs to be reminded to use the systems. So the systems I'm talking about are if the placement provider gives him a new piece of information or asks him to do something, Kris has a tendency not to remember what he has been asked. So we needed a system of: how are you going to remember that information? He now is asked to record the information so he can refer back to it either in that session or in subsequent sessions.
>
> My last observation of Kris was that despite having those systems in place he's not initiating the use of those systems. I needed to say, "How are you going to remember that information, Kris?" "Oh, we might write it down". "What information do we need to write down in order to be able to refer back to it?" But again I observed Kris later in the session not referring back to the piece of information he was given. All of these, I would expect somebody being routinely being able to use those systems as indicators of a level of employability on the open labour market.
>
> I would have current concerns about, from my observations and my experience of working with clients with acquired brain injury, with his level of cognitive difficulties, how he would function in open employment."

88. Her evidence was supported in this respect by Dr Warburg and by Dr O'Driscoll, who summed the matter up as follows:

> "[In respect of his employment prospects] I think quite poor. The reason I say that is because the job that he did have was, to all intents and purposes, a supported environment. His boss seemed to be extraordinarily tolerant of him. And he didn't seem to be able to, again, internalise, generalise or even empathise, at an emotional level, with what his boss was trying to do for him at the time. And although he was on a disciplinary and he had been cautioned for time keeping, it was noted that even when he would turn up late he would take the time to smoke outside the building before he even went in. And I think with that level of misunderstanding I find it very difficult to see that he would survive in a more competitive environment."

89. The Defendant placed weight on the fact that the Claimant had found work at Peacocks and had managed for a significant period to hold down the job. However, I

have had regard to the evidence in that respect and it is clear that at Peacocks he was extraordinarily fortunate to find a very sympathetic employer who was prepared to tolerate deficiencies in performance that would not usually be regarded as acceptable. The manager, Mr Bolland, set out in his witness statement the problems that he encountered, including poor timekeeping and attendance, and the level of control and surveillance that this challenging employee required. Given the present general conditions for young people in the job market, the Claimant's very substantial difficulties would be a real impediment to any employment.

90. In the light of this evidence I do not believe that it is at all realistic to conclude that the Claimant is likely to obtain and to retain paid employment, even on the relatively modest scale proposed by the Defendant.

General Damages for Pain and Suffering

91. In the Updated Schedule and Counter Schedule, the Claimant contends for £140,000 and the Defendant for £90,000.

92. Both parties refer to the 11th edition of *The Judicial College Guidelines for the Assessment of General Damages in Personal Injury Cases*. Both parties also agree that the appropriate category is moderate brain damage, but they disagree on the amount. The Defendant contends that an award of £140,000 would be appropriate only if, for example, the Claimant had suffered a moderate to severe intellectual deficit, a personality change, an effect on sight, speech and sense with a significant risk of epilepsy and no prospect of employment. The Claimant, it is submitted, falls into the second category, namely where there is moderate to modest intellectual deficit, the ability to work is greatly reduced if not removed and there is some risk of epilepsy. The bracket in that case is £64,750 to £107,250.

93. The present case does not fit neatly into the specific categories. I have found that it is not realistic to expect that the Claimant will be able to obtain, and retain, paid employment. There are significant continuing effects of his injury, where he has difficulties with, for example, concentration and organisation, and is prone to fatigue at a level that he would not otherwise have experienced. His reduced motivation and initiation is reflected in the continuing need for the support regime that I have indicated.

94. Taking account of all these factors, and with reference to the guidelines, I believe that the appropriate award under this heading for the Claimant is £120,000.

Final Award or Provisional Damages

95. The Claimant seeks an award of provisional damages whereby the risk of developing epilepsy as a result of the head injury is not taken into account. The power of the Court to award provisional damages is derived from section 32A of the Senior Courts Act 1981:

> "The section applies to an action for damages for personal injuries in which there is proved or admitted to be a chance that at some definite or indefinite time in the future the injured

> person … will develop some serious disease or suffer some serious deterioration in his physical or mental condition. ”

96. Dr Schady and Professor Barnes agree that the Claimant has a risk of developing epilepsy of 2-3 per cent. The risk in the general population is about 1 per cent. Both these experts also agree that there is a very good prospect that, if the risk were to eventuate, it could be fully controlled by medication, so that the risk of developing uncontrollable epilepsy is about 0.6 per cent.

97. The Defendant submits that the risk of the development of post-traumatic epilepsy not controllable by medication is so remote that the Court should not exercise its discretion in awarding provisional damages. The accident occurred more than 10 years ago. The Claimant has not suffered any epileptic episode in the meantime, and it is entirely unlikely that he will develop this condition or that, if he did so, the condition could not be controlled.

98. However, in my view, the risk identified by the experts remains a significant one, above the risk in the general population. I accept that there is a very good prospect that the condition could be controlled, even if it did eventuate, but there remains, on that hypothesis, a risk that it would not be controllable. That risk is not such that it would be right to treat it as negligible. Furthermore, I have determined that the support required by the Claimant can be substantially reduced over time. If the risk of uncontrolled epilepsy were to eventuate, the Claimant would then be likely to be seriously under-compensated for the actual loss that he had in the event suffered: see *Kotula v EDF Energy Networks (EPN) plc and others* [2011] EWHC 1546, at paragraphs 46-48. I shall, therefore, make an appropriate order for provisional damages.

Past and Future Professional Deputy and Court of Protection Costs

99. The Defendant contends that the past costs under this heading should be disallowed because, if District Judge Eldergill had known the full facts, he would not have made the order that he did. I deal with this matter in the Annex. I am not able to determine what order the District Judge would have made on that hypothesis. In any event, I have determined that the Claimant lacks capacity (and, therefore, has lacked capacity at least since the appointment of the deputy), and it would be wrong in principle to disallow costs that were incurred on what has now been established as a correct legal basis.

100. As to the reasonableness of future claimed costs, I see force in the Defendant’s submission that the level of future costs will depend upon the extent of future management and care. I have already decided what that level should be, and again I hope that the parties can agree this head of future cost in the light of that decision.

Conclusion

101. In the light of this judgment dealing with the issues remaining in dispute, the parties should be able to draw up an appropriate dispositive order.

ANNEX

1. Professor Barnes' evidence is so unreliable that it should be rejected for the following reasons:

2. In his report dated 22 January 2009 (this report was disclosed only on the last working day in the week before the trial began) Professor Barnes concluded that the Claimant had capacity:

> "I felt that he had sufficient grasp of the litigation and matters appertaining to property and his affairs. I do not feel that he needs to be deemed a Protected Party under the terms of the Mental Capacity Act. I note that this is the opinion of Dr Rosenbloom and Mr Baldwin." (My emphasis)

3. In coming to that conclusion, Professor Barnes had discussed the matter "…in great detail…" not only with the Claimant, but also with the principal individuals who had been supporting him since his accident, namely his mother and stepfather. Although Professor Barnes "noted" the opinions of Dr Rosenbloom and Mr Baldwin, each of these doctors had in fact concluded that the Claimant lacked capacity. Professor Barnes in his oral evidence to the Court was unable to explain how he had come to misread their assessments. He could not explain why he had put down the opposite conclusion. He described his error as "…embarrassing…".

4. On 6 October 2009 Professor Barnes produced a further report. This report did not mention at all the report of 22 January 2009 but was simply disclosed in the litigation as if it was his first report. In this report he expressed the conclusion "…on balance…" that the Claimant lacked capacity to manage the litigation and also to manage his own property and financial affairs. He held to and repeated this opinion in each of his subsequent reports. Until the Friday of the week prior to the trial, the Defendant was led to believe that this had always been his opinion.

5. Some light is shed on the circumstances in which Professor Barnes came to "revise" his opinion by a manuscript note that he made on 25 September 2009. He had had a telephone conversation with a litigation solicitor at Pannone, who then had conduct of the file. The note read:

> "Capacity. Rosenbloom and Baldwin said lacked capacity, not had it. I did. Await Bev Wild [case manager] witness statement which will [illegible] - but, according to Professor Barnes, possibly "explain" or "point out" - his problems. Re-do. Then repeat with new date and sentence to explain that I did it in January. Then revisit with new information and say lacks capacity." (My emphasis)

6. When Professor Barnes produced his report dated 6 October 2009, the report did not state that he had interviewed the Claimant and his mother and stepfather in January 2009. The report did not state that he had in any earlier report come to the opposite conclusion, and that he had since changed his mind, giving his reasons for the volte face.

7. The report of 6 October 2009 furthermore implies that Professor Barnes had recently visited and interviewed the Claimant and his mother and stepfather, shortly before 6 October 2009. However Professor Barnes in his oral evidence had no clear recollection of making such a visit. He had no diary entry to corroborate such a visit. He relied instead on his intention to make a visit as set out in his manuscript note dated 25 September 2009 and on the fact that he was in Manchester on 6 October 2009 to make three other visits. I am not able to conclude that Professor Barnes did visit the Claimant shortly before 6 October 2009, for the principal following reasons.

8. Professor Barnes was unable to produce any contemporaneous diary entry that he intended to visit or visited the Claimant at that time. None of the contemporaneous records [case management, support worker and occupational therapy] corroborate a visit from Professor Barnes. The records show that the Claimant went to Moston College and then to Manchester with Yvonne Ashworth [support worker] before returning home for lunch and then attending to his general practitioners. Neither Ms Ashworth nor the Claimant's mother, who spoke with the case manager on 6 October 2009, referred to any visit from Professor Barnes.

9. The report of 6 October 2009 does not disclose any information about events occurring in the Claimant's life between January and October 2009. There is no reference, for example, to his A level results nor to any factual matters which might have been significant in terms of reaching a judgment on capacity. Save for the passage on capacity the text of the reports of 22 January 2009 and 6 October 2009 is in precisely the same terms. The section on capacity contains no new material that might have been obtained from the Claimant, his mother or step-father.

10. I am not able to conclude with confidence that Professor Barnes made an independent assessment of the Claimant's capacity.

11. In the light of the objective circumstances the manuscript note of 25 September 2009 strongly suggests that Professor Barnes was minded to change his conclusion on capacity given simply what he had been told about Dr Rosenbloom's and Mr Baldwin's opinions. In his report of 6 October 2009 Professor Barnes failed to state that he had made a previous report in which he reached the opposite conclusion, failed to state how he had reached that conclusion and failed to state the precise circumstances in which he had changed his mind. In essence, furthermore, the report of 6 October 2009 contains no material information that was not available in January 2009.

12. It is also appropriate to consider how the issue of capacity was presented to the Court of Protection. There had been communication between the litigation and Court of Protection departments at Pannone in August and September 2008. Where a prospective client is bringing a personal injury claim, the litigation department would ordinarily obtain evidence on capacity. For reasons that are unclear, each department in this case separately commissioned its own medical evidence on capacity. The Court of Protection department obtained an opinion from Dr Huddy, to the effect that the Claimant had capacity, and the litigation department from Professor Barnes. By the end of March 2009 each department, therefore, had medical reports that the Claimant had capacity. Mr Jones, the partner for Court of Protection matters, closed his file, not having been sent a copy of Professor Barnes' report dated 22 January 2009 (which, it may be recalled, stated also that the Claimant had capacity).

Subsequently Mr Jones re-opened the file when he was sent a copy of Professor Barnes' later report dated 6 October 2009 (reversing his earlier assessment), whose conclusions were now at odds with those expressed by Dr Huddy.

13. Professor Barnes was not sent a copy of Dr Huddy's report at any stage. District Judge Eldergill was unaware, when he made the order on 28 April 2010 appointing Mr Hugh Jones as the Claimant's deputy, that there was any medical evidence to the effect that the Claimant had capacity. He was not told about Dr Huddy's report, nor did he have any inkling of the circumstances, set out in detail above, in which Professor Barnes came to give his "revised" opinion, nor that no-one at Pannone had shown the report of Dr Huddy to Professor Barnes.

14. In my view, this was a case where all available medical evidence relevant to the issue of capacity should have been disclosed to the Court, including the reports of Dr Rosenbloom and Mr Baldwin, both reports of Professor Barnes dated 22 January 2009 and 6 October 2009 and the report of Dr Huddy. It was essential that Professor Barnes be shown the report of Dr Huddy, because Professor Barnes was performing a volte face that was not supported by Dr Huddy's conclusion. It is then almost certain that the Court, faced with this welter of conflicting medical opinion and aware of Professor Barnes' volte face and the deeply unsatisfactory scenario that had unfolded, would have refused to determine the application on paper, but would have insisted on an oral hearing at which the issue could have been fully and properly considered. I am unwilling to speculate as to what the outcome might have been if a proper procedure had been followed at that time, but the possibility cannot be ruled out that the Court might at that time have found that the Claimant had capacity. In the light of my own conclusion such a finding, although not unreasonable, would have been incorrect.

15. All I need add is that the lamentable failures that occurred here, and the invidious position in which the judge in the Court of Protection was unwittingly placed, must never be repeated. The issue of capacity is of very great importance, and all involved must ensure that the Court of Protection has all the material which, on proper reflection, is necessary for a just and accurate decision.