
ROYAL · COURTS · OF · JUSTICE

Neutral Citation Number [2023] EWHC 1470 (SCCO)

SCCO Ref: SC-2019-BTP-000495

IN THE HIGH COURT OF JUSTICE

SENIOR COURTS COSTS OFFICE

Thomas More Building
Royal Courts of Justice
London, WC2A 2LL

Hearing Date:21/09/2020
Judgment 09/06/2023

Before:

COSTS JUDGE JAMES

- -

BETWEEN:

Michael Briley	First Claimant
Jacqueline Briley	Second Claimant
Simon Briley	Third Claimant

- and -

Leicester Partnership NHS Trust	First Defendant
University Hospitals Leicester NHS Trust	Second Defendant
East Leicestershire and Rutland Clinical Commissioning Group	Third Defendant

Mr Joseph Buckley, Costs Lawyer (instructed by Bhatt Murphy) for the Claimants
Mr Matthew Smith, Counsel (instructed by Acumension Limited)

JUDGMENT

Apology

1. This matter was heard as long ago as 21 September 2020 when I heard it during the Covid-19 Pandemic. Entirely regrettably, and due to no fault of either party, it has taken until now to produce this Judgment. This was partly due to the Covid-19 pandemic and the disruption it caused but also due to other factors of which the parties are aware but which I do not include here, not least because whilst those factors explain the delay, I readily accept that they do not excuse it. I can only apologise which I do with sincerity and gratitude for the forbearance which the parties have shown. The parties

were represented at the hearing by Mr Joseph Buckley for the Claimants with Ms Megan Phillips, the Solicitor who acted for the Claimants at Bhatt Murphy and who was able to assist me with various factual issues from the case, and Mr Matthew Smith (Counsel for the Defendants). All of the advocates were very helpful and I am grateful to them for their attention to detail in this case.

Background – lead up to death of Amanda Briley

2. This case involves the tragic early death of Amanda Briley ('Amanda') a young woman born on 25 August 1996, who passed away on 28 December 2016. Amanda began suffering from self-harming behaviour and mental health difficulties around the age of 12 and was referred to Child and Adolescent Mental Health Services ("CAMHS"), where she was under care of the First Defendant since 2013. She was home schooled, given the difficulties she faced attending mainstream education. At 15 years of age, Amanda was diagnosed with Asperger's Syndrome, later receiving a further diagnosis of emotional unstable personality disorder. From a young age, Amanda had multiple inpatient stays with CAMHS and at the Bradgate Mental Health Unit ('the Bradgate Unit'). From 2012 to 2016, Amanda suffered numerous serious self-harm and suicide attempts and was admitted to several mental health units, including in crisis.

3. Amanda was referred to the PIER Team (Early Intervention and Psychosis Service) in January 2014 as it was thought that her presentation may be due to some form of psychosis. Following an assessment in October 2014, Amanda remained with the PIER Team given the diagnosis of psychosis could not be wholly ruled out. She remained under their care during her time at the Bradgate Unit and until her death. Their contact with Amanda was extensive as was their communication with the Bradgate Unit. During 2016, Amanda's mental health and behaviour worsened and it was no longer safe for her to remain at home given the self-harm and suicide attempts. Consideration was given to whether her actions were intended to provoke a response from them and therefore a form of communication/'cry for help' given her Asperger's Syndrome rather than being deliberate attempts to end her life.

4. Through PIER Amanda was admitted to the Bradgate Unit (Heather Ward) following an incident of crisis on 25 January 2016, but being relatively stable during this time Amanda was discharged from the Bradgate Unit on 16 February 2016, albeit without consultation with her PIER workers.

5. Amanda remained under the care of mental health services and PIER but throughout April 2016, her mood fluctuated. In addition, she wished to reduce the Olanzapine that she had been prescribed given the side effects she was suffering. The crisis team arranged a planned admission to the Bradgate Unit

and this was escalated when it became clear that Amanda's distress was increasing; she was communicating that she was unable to keep herself safe, did not want to take her medication anymore and felt hopeless about her future. She was admitted on 7 May 2016 to Ashton Ward. A reduction in Olanzapine continued and, throughout this time, Amanda was attending autism outreach, an educational establishment, and was therefore on leave for that attendance. Amanda was officially discharged from the Bradgate Unit on 2 June 2016.

6. On 3 June 2016, Amanda took an overdose and made her way to a motorway bridge. On the way she called an ambulance. Amanda had previously attempted self-harm through jumping off motorway bridges, including one instance in which she fractured her spine. Amanda was subsequently readmitted on 4 June 2016 to the Bradgate Unit. In addition, at this time Amanda began to report again sensory and auditory hallucinations and a re-emerging of a character whom she referred to as 'Declan' who had featured previously in Amanda's 'hallucinations', including her reporting that she had been raped by him at the age of 13 but who (on occasion) she had also described as her boyfriend.

7. In June 2016, PIER met with those providing Amanda's care at the Bradgate Unit and documents were completed as requested by the ward applying for funding for specialist treatment and care for Amanda. It was recognised by both PIER and the consultant psychiatrist in charge of Amanda's care, Dr Pingili, that the complexity of her needs in terms of her Asperger's Syndrome and other diagnoses far exceeded the resources of the ward where she was, and that a more appropriate specialist placement needed to be identified. Numerous attempts were made to locate a suitable establishment, somewhere that would be able to work with Amanda for a psychological and functional approach and which could also meet the needs presented by Asperger's Syndrome, in addition to ensuring that she remained safe.

8. Amanda continued to self-harm throughout this time, including in the presence of staff members. She was predominately on level 1B and 1A observations, occasionally briefly dropping to level 2 observations. She reported to numerous individuals but she felt safe when there was someone with her. Level 1B observations involved an individual being in the room with Amanda and Level 1A involved an individual being constantly within arm's reach of her. Ligature attempts were also attempted throughout this period. On 16 July 2016, Amanda was placed on Section 5(2) of the Mental Health Act following a ligature attempt on the ward. She was subsequently detained under Section 2 of the Mental Health Act on 18 July 2016, and this was regraded to Section 3 of the Mental Health Act on 12 August 2016.

9. Amanda was seen in a ward round on 8 September 2016 and her observation levels were reduced from intermittent to general. The level of observations was then increased to level 2 10 minute observations, with a view to reducing further, but on 9 September 2016, Amanda attempted to ligature with her trousers at 12.40pm, and again ligatured at 15.30pm with earphones. There was a further serious incident on 11 September 2016 while Amanda was an inpatient on Beaumont Ward. She was on level 2 intermittent observations and found on her bathroom floor having tied her trousers around her neck several times. She required external hospital treatment and fortunately recovered. There were serious concerns in relation to the failure of any investigation to take place following that incident which was due to the investigator 'forgetting' to complete the investigation.

10. Attempts by PIER to obtain a suitable placement for Amanda continued and failures in relation to obtaining the necessary funding involved a delay in funding being applied for and subsequently granted. The delay lasted from 24 August 2016 until 8 November 2016, at which point a suitable placement was located for Amanda in Warrington. This was only resolved when PIER contacted NHS Arden and Greater East Midlands Commissioning Support Unit, given the lack of information about funding for a bed. It was at this stage that PIER were informed that nothing was known about an application for funding, with the person responsible for actioning the request having left the post in recent weeks and no-one having taken over progression of it. Funding was finally secured for a suitable placement for Amanda on 28 November 2016, one calendar month before she passed away.

11. Throughout this time, it was the opinion of all involved in Amanda's care that her placement on Bradgate Unit was wholly unsuitable for her complex needs. This was confirmed in the witness evidence from the warden matron at the Bradgate Unit. The placement was not intended to be and should never have been long term. Amanda was allowed very little leave given risks to herself from June until December 2016; leave took place on only a handful of occasions and she was always escorted. However, in December 2016 at a ward round meeting, the possibility was raised of Amanda going home for Christmas day. Once leave was mentioned, on 17 December 2016, a detailed plan regarding overnight leave for 24 December 2016 was made in collaboration with Amanda's named nurse, Zahra Makhany. The plan working up to leave on 24 December 2016 was set out in a care plan to be approved by a psychiatrist in the multi-disciplinary team.

12. The plan was also put on Amanda's bedroom wall, which was particularly important as Amanda's diagnosis meant that it was incredibly important for her to know a plan for what was going to happen on a daily basis and also for that plan to be followed. Any change could lead her to experience extreme confusion and distress.

13. The multi-disciplinary team agreed the plan on 20 December 2016. The plan included details of the observations, reducing them so that Amanda was on level 3 general observations by the time the planned leave started on 24 December 2016. However, the observations were not reduced in accordance with the plan and the plan was not referenced on the handover sheet. This was despite the speech and language therapist, with whom Amanda had regular and consistent contact, documenting on her RIO notes how the visual schedule helped her manage her feelings in being prepared for changes to her observations. Indeed, the SALT assistant documented that not only did he add these notes on but he also telephoned the ward and spoke to a health care assistant requesting that his note be read.

14. In addition, the plan for Amanda's leave and the reduction in her observations as per the plan, were not discussed with her parents. They were understandably concerned about their ability to keep Amanda safe but, once the leave had been mentioned to Amanda, they were equally concerned about any effect that any cancellation of that leave would have on her and her mental well-being.

15. In the plan it was made clear that there had been an increase in the observation levels (to Level 1, i.e. constant observations as described above) planned for Amanda's return from leave on 25 December 2016 given all professionals' concerns that she would suffer "come down" after her return from Christmas leave. However, the plan for constant observation levels was not recorded in subsequent documents or communicated to the staff in charge of Amanda on her return from leave. The rationale behind that was lost from the records from 20 December 2016 onwards. Indeed, the handovers and progress notes did not reflect the plan or Amanda's schedule.

16. The plan for observations and schedule for observations written on the handover sheet on 21 December 2016 outlined those in the original schedule, however, stopped on 24 December 2016. Therefore, the plan for level 1 observation on 25 December 2016 following Amanda's return from leave was missed. In addition, Amanda's regular consultant was on leave and a covering consultant psychiatrist requested that a junior doctor speak to Amanda's family and confirm that they were happy with the suggested overnight leave. Amanda's family confirmed their concern that Amanda would react badly if she was not now allowed overnight leave and they were therefore happy to have her overnight for one night at her grandparents address as it was not considered safe for Amanda to return to her home address.

17. Amanda went on to general observations on 24 December 2016 but on her return from leave, which passed without incident, Amanda was placed on level 3 general observations as opposed to level 1, constant observation, as was supposed to have been the plan. The explanation from nursing staff for

the level of observations was that Amanda was on level 3 general observations prior to going on leave and there was no other indication of the plan for her return on level 1 observations following leave. Amanda's consultant psychiatrist stated that it had been agreed with the multi-disciplinary team that Amanda would be nursed on level 1B observations on return from leave on Christmas day. The consultant who was covering for Amanda's consultant while he was on leave at Christmas said that there was no reason not to support the schedule that Amanda had agreed with her team however, he was unaware of the plan identified for her to return from leave on level 1B and did not therefore discuss this with Amanda or ensure that it was recorded in the notes. The care plan had been developed with Amanda's involvement by her named nurse on 3 September 2016, but again, this was not referred to.

Amanda's death and subsequent steps taken by her family

18. Early on Boxing Day, 26 December 2016, Amanda was found on the floor of her bedroom having ligatured with her trousers/leggings. Resuscitation was attempted, following which she was transferred to the Leicester Royal Infirmary however she was declared deceased on 28 December 2016 having suffered an un-survivable hypoxic brain injury. Following Amanda's death, a serious incident investigation was carried out. The investigation raised concerns and identified failings over:

- Communication between the ward and the PIER team, the ward and the family and as contained in the documentation which followed;
- The suitability of the placement at Bradgate Unit;
- The serious delay in obtaining funding for a specialist placement more suited to Amanda's needs; and
- Safeguarding concerns in relation to Amanda and her reporting of rapes: it is for this reason that I have put the word 'hallucinations' in paragraph 6 above, in regard to 'Declan', into inverted commas; a vulnerable young woman was reporting rapes but at the time it seems they were simply written off.

19. The panel conducting the serious incident investigation found that Amanda's extended stay at the Bradgate Unit was the root cause of the incident, finding both that the environment at the Bradgate Unit was detrimental to Amanda's well-being and that the length of time taken to identify a suitable placement and uncertainty around the plans caused confusion and anxiety for her. It was considered that Amanda's complex learning disability needs and challenges presented extreme difficulty for staff to manage alongside other patients in that setting.

20. In relation to the failure to care for Amanda by level 1 constant observations when she returned from leave on Christmas Day, the panel found that this was an antecedent rather than a root cause. The investigation highlighted that the failure was primarily a system error due to Amanda presenting with a need for an approach for observations that the team at the Bradgate Unit and the systems there in place were not equipped to provide. A serious concern was also raised by West Midlands Ambulance Service as to the CPR that was being conducted upon Amanda immediately upon her being discovered.

21. The concerns surrounding these tragic events led to an investigation and a future Inquest touching upon Amanda's death. Instructions were received to act on behalf of the Claimants (Amanda's family) in a claim against the Defendants for declaratory relief and damages, including aggravated damages, arising from the acts and omissions of the Defendants' employees, servants and/or agents. The claims were brought pursuant to the Law Reform (Miscellaneous Provisions) Act 1934, the Fatal Accidents Act 1976 and the common law for negligence and in respect of breaches of the Human Rights Act 1998 (Articles 2, 3, 8 and 14 of the European Convention on Human Rights) and the Equality Act 2010.

22. The Claimants brought the claims in their own right and, in addition, the First Claimant brought the claim on behalf of the Estate of his daughter, Amanda Briley, arising from events leading to the admission of Amanda as a psychiatric patient at the Bradgate Unit, Leicestershire, on 4 June 2016 and events whilst she was a patient at that unit, including events leading to her death on 28 December 2016 at Leicester Royal Infirmary as well as events following her death.

23. Upon receipt of instructions from the Claimants, steps were taken to write to the Coroner requesting all disclosure. A pre-Inquest review hearing was listed on 17 May 2017 however there was an adjournment of the same to allow the ongoing investigations into Amanda's death to conclude and for full reports to be provided. Matters considered included the Serious Incident Investigation Report received in May 2017, as well as disclosure received from the Coroner and Claimants throughout June to August 2017. This included numerous handwritten records and witness statements.

24. Extensive medical records were also obtained, which had to be carefully reviewed given the irrational order in which they were received, and a comprehensive chronology was prepared. Witness statements and a further report provided by the First Defendant, were received and the information contained therein regarding the responsibilities for delay were considered, and the correct Defendants identified for purposes of issuing proceedings.

25. On 8 December 2017, the Claimants filed an Application Notice and draft Order for permission (pursuant to Section 139 of the Mental Health Act 1983) to bring proceedings. The Claimants' application was adjourned with liberty to restore with evidence and argument as to why the Court should give leave. Steps were taken to prepare the Witness Statement of Ms Megan Phillips to assist the Court by providing further information insofar as it was known to the Claimants in respect of the proposed claims. The witness statement was filed on 13 December 2017, together with the original Application Notice and the Order of Phillips J dated 8 December 2017. A Consent Order was subsequently granted providing the Claimants with leave to bring proceedings against the Defendants under Section 3 of the Mental Health Act 1983. The Claim Form was then filed on 15 December 2017.

26. A pre-Inquest review hearing took place on 11 December 2017. The interested persons were established and it was confirmed that a Jury would be summoned and that it would be an Article 2 Inquest. The parties were directed to provide written submissions for expert evidence and disclosure, as well as provide all statements and question and answer interviews associated with the Serious Incident Investigation Report. Directions were also made for disclosure of witness statements and medical records.

27. In January 2018, further voluminous medical records were received from the First Defendant, which were again supplied in an irrational order. The records, which included handwritten records and progress notes covering four years, were carefully reviewed and entries were flagged in order to obtain instructions from the Claimants. In addition, the records missing were identified. A detailed witness statement was then prepared on behalf of the Second Claimant. In February 2018, further witness statements were disclosed as well as a report regarding the examination of Amanda's mobile phone prepared by DC Evans. It was extremely important for the contents of Amanda's phone to be reviewed, particularly given reference to her having sent text messages to support staff.

28. In March 2018, submissions were made to the Coroner regarding expert evidence, which would assist with liability for the civil claim. Dr Camden Smith, Psychiatrist, was subsequently instructed, as well as Dr Stephen Edgeley, Nursing Expert, to consider clinical nursing issues. Further disclosure was received from the First Defendant, including CRASH records, as well as Leicestershire County Council. On 12 April 2018, the Claimants filed an Application Notice for an Order for an extension of time for service of the Particulars of Claim. A Consent Order dated 25 May 2018 was subsequently made providing an extension of time for service until 15 February 2019.

29. In May 2018, extensive bundles of medical records were received from the First Defendant. Consideration was given to the safeguarding records, lengthy witness statements, reports and detailed case notes and exhibits received from the First Defendant and Leicester County Council. Disclosure was also received from the Third Defendant which was reviewed and a detailed list of all disclosure which had not been received was prepared.

30. The matter was listed for a further pre-Inquest review hearing on 30 May 2018. The second pre-Inquest review hearing largely focussed on the jury, Article 2, scope, disclosure and witness evidence. In July 2018, consideration was given to drawings made by Amanda and the Coroner was approached for permission to prepare a statement on behalf of the Claimants exhibiting the drawings and explaining the context of the same.

31. On 25 July 2018, a Part 36 offer was made on behalf of all three Defendants in the sum of £32,500 plus costs. A quantum assessment was undertaken accordingly and the Claimants were advised in respect of quantum of all causes of action. The Defendants' offer was not accompanied by an admission of liability, on which the Claimants placed a significant degree of importance. A detailed response to the Defendants' Part 36 offer was provided on 15 August 2018. The detailed letter set out the causes of action being brought and invited the Defendants to consider making admissions of liability. The Defendants' offer of settlement was also rejected.

32. The Defendants responded on 30 August 2018 stating that "the lack of any non-pecuniary remedies should not frustrate settlement" of the matter. Nonetheless, the Defendants requested the Claimants to prepare draft wording for the letter of apology for them to consider. The Claimants responded on 27 September 2018 setting out the admissions of liability sought and, on the same date, the First Defendant responded confirming that instructions were being sought on behalf of all Defendants in respect of full admissions of liability. The appropriate wording of the draft letter of apology was of course dependent in part on which, if any, admissions were to be made, and by whom. Therefore, the draft wording of the letter of apology could not be prepared until the admissions of liability were received.

33. Throughout the lead up to the Inquest, there was significant concern and discussion regarding the First Defendant's approach to disclosure, which ultimately resulted in disclosure of over 7,000 pages of material following the Claimants' request for the same prior to agreeing any settlement. On 10 October 2018, the First Defendant confirmed that they would be arranging full disclosure of Amanda's medical records in order to ensure that the Claimants have full disclosure to enable them to fully evaluate the claim. An updated witness list was provided by the Coroner and steps were

taken to rationalise the witness disclosure accordingly. Additional witness evidence of Emma Weir, the key manager responsible for PIER at the time of Amanda's death, and Helen Monaghan, in relation to the lack of bed availability at St Mary's Hospital, was disclosed and consideration was given to the impact on the claim and Inquest.

34. On 26 October 2018, the Defendants made a further Part 36 offer in the sum of £65,000 plus costs, however again, the offer was not supported by full admissions of liability. The Claimants wrote to the Defendants once more on 30 October 2018 requesting confirmation that such admissions would be made and reiterating the importance of the same. Detailed submissions were prepared to the Coroner regarding witnesses who did not appear on the witness list and explanations were provided as to the reasons why evidence needed to be heard from those witnesses. In early November 2018, the extensive disclosure received from the First Defendant and the Coroner was carefully reviewed. On 3 November 2018, the First and Second Defendants admitted liability in respect of all causes of action and agreed commitment in respect of the Claimants' involvement in learning future lessons. Instructions were obtained from the Claimants in relation to the draft wording of the letter of apology and the same was provided to the First Defendant on 15 November 2018.

35. The Defendants' Part 36 offer was accepted by the Claimants on 16 November 2018, the Friday before the Inquest commenced on 19 November 2018. The letters of apology were received thereafter. Per the Claimants, the time spent in preparation for the pre-Inquest review hearings and Inquest was all of direct relevance to the civil claim and assisted in achieving such an early settlement. The settlement was accompanied by full admissions of liability in respect of all causes of action, a letter of apology and a commitment to involving the family in training and/or learning lessons from Amanda's death.

Defendants' case on the Preliminary Issues –taken from the Points of Reply as elaborated upon by Counsel at the hearing before me.

36. General Point 1 was addressed at the hearing; Mr Smith advised that it required no particular ruling as it was simply a recitation of the Defendants' position regarding reducing any items I might not be minded to disallow. Point 3 is simply an overview of the Bill which again required no ruling and was also duly noted.

37. Point 2 (on retainer/indemnity principle) was addressed during the hearing and, in brief, Mr Smith asked me to look at the retainer documents; he accepted there was no reason to go behind the certificate on the Bill but wished me to review the documents so as to be satisfied that it was in order

and (in particular) to check the hourly rates. In this case, there was Legal Help/Exceptional Funding for the Inquest (including pre-Inquest reviews) running alongside the CFAs for the litigation; Mr Buckley referred to a decision of Master Rowley in *Matthews* that this funding 'abuts' the CFAs but that it should make no difference to how the costs were dealt with.

38. It matters not to any great extent in that, had the Claimants lost, they would have recovered the Inquest costs at Legal Aid rates, but since they won, they claim those costs at market rates which (as the indemnity principle is specifically disapplied in those circumstances) they are entitled to do subject to pre-Inquest costs being recoverable at all. I checked the funding documents, verified that the hourly rates in the Bill were as per the rates in the CFAs and that distance selling regulations had been complied with; I saw nothing amiss and Mr Smith acknowledged the position. There was some discussion of the public policy behind it and so on, but as this was academic in nature it need not be recorded here: it was a reasonable question to ask in the Points of Dispute but there is no technical point to be had and Mr Smith accepted this.

Point 4

39. As to Point 4, the parties' respective positions on hourly rates, in table form, are as follows:

Fee Earner	London 3 GHR	C Rates claimed	Band 2 GHR	D Rates offered
Ms Phillips Grade A	229.00-267.00	350.00	201.00	225.00
Ms Solopova Grade D	121.00	140.00	111.00	111.00
Mr Ferdinand Grade D	121.00	140.00	111.00	111.00
Ms Carini Grade D	121.00	140.00	111.00	111.00
Ms Lisette Grade D	121.00	140.00	111.00	111.00
Costs consultant	121.00	150.00	111.00	111.00

40. The Defendants invited me to reserve my Judgment on Point 4 until I handed down my decision on Point 6 (Point 5, on Proportionality, being governed by *West* and not ready for decision at this stage). Mr Smith submitted that the Claimants have claimed excessive hourly rates throughout and that the fee earner (Ms Phillips) could not claim to have been 'punching above her weight' and that Points 4 and 6 needed to be considered together accordingly. It was necessary to go into a good deal of detail on the history and chronology of the matter just on those two Points but if the remaining issues cannot be negotiated away and need a further hearing, that level of detail will be of assistance – to be

clear, given the length of time it took to produce this Judgment I have listened to the recording of the hearing so as to refresh my memory on the full detail.

41. Without reciting verbatim the Point of Dispute, or Mr Smith's helpful submissions, there was some Grade D and Costs Consultant time, but the 'lion's share' and the meat of the dispute between the parties relates to time spent by Ms Phillips, a Solicitor being charged at £350.00 per hour. The Defendants assert that as the Claimants reside in Leicester, it was not objectively reasonable to instruct Bhatt Murphy in Dalston (London 3). At the hearing Mr Smith accepted that the starting rates in London 3 and in National (Band 2) are fairly close.

42. The Defendants cite *Wraith v Sheffield Forgemasters* [1988] 1 WLR 132 and *A v Chief Constable of South Yorkshire* [2008] EWHC 1658 (QB) but although those are well-established precedents they are not applied, as such, in the Points of Dispute. The Defendants rely upon the 'heavy' involvement of Counsel as a factor that should have mitigated the Solicitors' hourly rates. In particular they submit that only the hourly rate of Ms Phillips as the main conducting fee earner, should be enhanced, as responsibility for the majority of the salient work was 'foisted onto the shoulders of Counsel' (per the Defendants). They say that the degree of departure from the Guideline Hourly Rates ('GHR') and they say these should be the National Band 2 GHR, is unreasonable.

43. The Defendants assert that a National (Band 2) firm from in/around Leicester would be 'more than capable' of conducting this litigation, adding that research by them on the Law Society website had located 9 Clinical Negligence firms within 20 miles (of the Claimants) who accept Legal Aid. At the hearing, Mr Smith referred to Duncan Lewis in Birmingham and Leicester, as well as to Irwin Mitchell who also have offices in the Midlands (but who Mr Smith indicated would not have taken it on under Legal Aid). Mr Smith reminded me that, as this is a Standard Basis assessment, if I am in any doubt, I must resolve that doubt in the Defendants' favour.

44. A new point at the hearing, having seen the Replies (which was not the case when the Points of Dispute were prepared) Mr Smith referred to the fact that Mr Bhatt of Bhatt Murphy is a founding member of INQUEST and that as such the fact that INQUEST recommended that firm to the Claimants, really does not assist them. The Claimants would not (he said) have paid close attention to hourly rates given that the matter was funded either by the Legal Aid Agency or by a CFA but also as it was of such importance to them that the issue of costs would not have been foremost in their minds. It is right to add that Mr Buckley later pointed out that the Legal Aid provided, involved a request for a contribution, and that the CFAs involved them in agreeing to pay disbursements as well, so that it would not be correct to say that the expense of all of this was immaterial to them.

45. Inflation is not (per Mr Smith) relevant – pausing here, the GHR were recently substantially increased but when the last review took place in 2014 the Master of the Rolls took the view that they were, if anything, too high, but that he would not decrease them given that a low number of practitioners had provided any detail and he did not consider that there was a big enough sample upon which to take such a decision.

46. At the hearing, Mr Smith referred to the level of Counsels' involvement, both in terms of cost and time spent by Mr Desai of Matrix Chambers and Ms Sikand of Garden Court Chambers and in particular he referred to Mr Desai considering the Expert's CV, considering the language in the Claim Form, and s. 139 Application for Permission, as well as working on the letter of settlement – Mr Smith described it as a very high level of involvement by Counsel and stated that, because of it, Ms Phillips could not be described as 'punching above her weight'. He referred to other case law (*JXA*) in which Fieldfisher were awarded £350 per hour, pointing out that that was a £20 million Clinical Negligence claim. Here, whilst the circumstances were tragic, the complexity simply did not bear comparison.

47. The Defendants refer (in the Points of Dispute) to the need to review the amount of money or property involved, as well as the importance of the cause or matter to the parties, by reference to other Clinical Negligence cases, and cite *(1) KMT, (2) KAY, (3) MEY, (4) MJY (Children proceedings by their Litigation Friend the Official Solicitor) v Kent County Council* [2012] EWHC 2088 QB, which is interesting as in that case Eady J found on Appeal that the Costs Judge was well within his remit to award rates in excess of Central London rates after consideration of the factors listed in the former CPR 44.5 (3).

48. The Defendants' Points of Dispute also refer to but do not really apply *Johnson v Reed Corrugated Cases Ltd* [1992] 1 All ER 169 and *Brush v Bower Cotton and Bower* [1993] 1 WLR 1325 and suggest that a large complex case may warrant an enhancement of up to 70% but that anything in excess of that level must approach the 'exceptional'. They add (but again do not really apply) *Higgs v Camden & Islington Health Authority* [2003] EWHC 15 (QB) and *Finley v Glaxo* (1989, unreported – they say – in fact it appears in the 1997 Costs Law Reports at page 109 under *Finley v Glaxo Laboratories Limited*). *Higgs* is relied upon because in that case 100% was allowed in circumstances where there were 'exceptional' circumstances including hypoxic brain injury, dyskinetic cerebral palsy, liability contested to the door of the Court, and sums in issue of £6.1 million (as pleaded) and £3.8 million (settlement amount): per the Defendants, this case cannot warrant those sorts of rates.

Point 6

49. As to point 6, the legal costs incurred during the pre-Inquest review hearings, these were totalled by the Defendants at £14,736.42; in fact they come to £14,770.67 as to £7,587.50 Counsel's fees, £6,349.00 Solicitors' Costs and £834.17 travelling expenses (Counsel and Solicitors). As the matter settled before the Inquest 'proper' took place these were not costs of that Inquest, nor of the ancillary Advices, Conferences or documents times during the Inquest proceedings.

50. Per the Defendants, the legal costs in this matter spiralled out of all context with the value of the claim, before the Defendants even had an opportunity to address the civil claim facing them; the Claimants' Solicitors were said to have provided a 'platinum legal service' to the Claimants, including what is described as a 'weighty legal presence' throughout the Inquest process, whilst incurring an 'eye-watering' legal spend without regard to consideration of proportionality, adding that, no doubt if the Inquest costs had been incurred the legal costs would have been significantly higher still.

51. The Defendants refer to the dicta of Judge Alton in *Jefferson v National Freight carriers Ltd* [2001] 2 Costs LR 313, Neutral Citation Number: [2001] EWCA Civ 2082; in fact they mean Lord Woolf who cited with approval at paragraph 40 of *Jefferson* that learned Judge's decision in an unnamed matter in the Birmingham County Court on 22 June 2000, when he stated,
"In modern litigation, with the emphasis on proportionality, it is necessary for parties to make an assessment at the outset of the likely value of the claim and its importance and complexity, and then to plan in advance the necessary work, the appropriate level of person to carry out the work, the overall time which would be necessary and appropriate to spend on the various stages in bringing the action to trial, and the likely overall cost. While it was not unusual for costs to exceed the amount in issue, it was, in the context of modest litigation such as the present case, one reason for seeking to curb the amount of work done, and the cost by reference to the need for proportionality."

52. Per the Defendants, only costs 'of and incidental to' the civil claim are recoverable, relying upon *Roach v The Home Office* [2009] EWCH 312 QB, and dispute all times or items associated with matters of procedure, including attending at pre-Inquest hearings, assisting the Coroner, listening to Witness Statements being read aloud, and the verdict. Pausing here, that appears to be a 'cut and pasted' Point of Dispute as it is clear that the matter was settled shortly before the Inquest ever took place and that the costs of that Inquest do not appear in this Bill.

53. The Defendants challenge all costs associated with client care and travel expenses, referencing the SCCO Judgment of Master Rowley (as he then was) in *Amanda Helen Lynch (Representative of the Estate of Colette Lynch) and Others v (1) Chief Constable of Warwickshire Police (2) Warwickshire County Council and (3) Warwickshire NHS Trust* [14 November 2014]. They also refer to *Humberstone R (on the Application of) v Legal Services Commission* [2010] EWCA Civ 1479, *Jacqueline King (Administratrix of the Estate of Robert Gadd, Deceased) v Milton Keynes General NHS Trust* (2004) a decision of the now Senior Costs Judge, Master Gordon-Saker, in the SCCO from 13 May 2004. They also refer to *(1) Stewart (2) Howard v Medway NHS Trust* being a decision of Master O'Hare in the SCCO on 6 April 2004.

54. Mr Smith developed submissions on the case law during the hearing before me and also referred to *Fullick & Ors v The Commissioner of Police for the Metropolis* [2019] EWHC 1941 (QB); that is a case in which the Court approved the inclusion of pre-Inquest costs in the Claimants' Bill whereas in *Lynch* the Court did not. As Mr Smith pointed out, each case must turn on its own facts, with Proportionality being of central importance, along with the relevance (if any) to the civil claim. The question he said I must ask myself is, how did the Claimants' participation in the pre-Inquest reviews help their claims against the Defendants? Is this a case (as per *Lynch*) whereby the benefit to the Claimants was insufficient to justify the costs now being claimed? I was referred to various documents and in particular to an 'unqualified' admission, and asked how would further participation in the pre-Inquest reviews, assist on quantum or otherwise?

55. Finally, the Defendants referred to *In re Gibson's Settlement Trusts* [1981] Ch 179, 1 All ER 233. Inquest costs, in order to be recoverable, must be:

    (a) Of use and service in the claim
    (b) Relevant to the matters in issue in the claim and
    (c) Attributable to the Defendants' conduct (all three tests must be passed).

56. Per the Defendants, the Court should bear the following in mind:

    i. In May 2018, extensive bundles of medical records were received from the First Defendant (Leicestershire Partnership NHS Trust) including safeguarding records, lengthy Witness Statements, reports and detailed case notes from the First Defendant and from Leicester County Council, with disclosure also coming from the Third Defendant (East Leicestershire and Rutland Clinical Commissioning Group).

ii. *Coroner's (Inquests) Rules* 2013, Rule 13 – the Rules implemented a disclosure regime that sees full disclosure to the interested parties, which automatically includes Amanda's family, occurring *'at the earliest opportunity, and certainly before the Inquest commences'*.

iii. A Letter of Apology was sent from the Chief Executive of LPT [sic – presume this is the First Defendant] to the Claimants' Solicitors, dated 20 October 2017

Not on Defendants' chronology 11 December 2017 – first pre-Inquest review hearing

Not on Defendants' chronology 30 May 2018 – second pre-Inquest review hearing

iv. The First and Second Defendants made full liability admissions prior to the Inquest (hence why there is no attempt to recover the costs of attending the Inquest in the Bill of Costs. The Third Defendant *'had limited involvement in the proceedings in any event.'*

v. The Defendants engaged in negotiations on 25 July 2018 and presented the Claimants with a Part 36 offer in the sum of £32,500 plus costs.

vi. A Part 36 offer was made on 26 October 2018 in the sum of £65,000, covering all three Defendants. The Claimants accepted the offer on 16 November 2018.

57. At the hearing before me, Mr Smith recognised that it would be wrong to disallow all of the time at the Inquest, but as the case settled prior to the Inquest, that was not the issue. General 'housekeeping' at the pre-Inquest reviews would not be recoverable and I was encouraged to undertake a proportionate investigation into what should be recoverable in this case.

58. Mr Smith referred to *Kazakhstan Kagazy plc v Zhunus* [2015] EWHC 404 (Comm) which established that:

"The touchstone is not the amount of costs which it was in a party's best interests to incur but the lowest amount which it could reasonably have been expected to spend in order to have its case conducted and presented proficiently, having regard to all the relevant circumstances. Expenditure over and above this level should be for a party's own account and not recoverable from the other party."

Pausing here, Mr Justice Leggatt of course made those observations on the facts and circumstances of the particular (very high value) case before him.

59. Mr Smith gave a long list of facts in Amanda's case, in addition to those already enumerated above, he referred to an incident in September 2016 when she banged her head and suffered a concussion, as well as to yet another ligature attempt around this time, where she went unconscious. This was clearly a serious incident yet, at the time of her death, no Serious Incident Report had been made. He

referred to the visual 'map' timetable by which, as she had discussed, Amanda was expecting, upon returning from Christmas and feeling 'deflated' to be on level 1B supervision, i.e. in constant line of sight.

60. Instead, she was put on hourly supervision, and between visits at 02:00 and 03:00 on Boxing Day 2016, ligatured herself so as eventually to lead to her death from a non-survivable hypoxic brain injury two days later. It was clear that she was a suicide risk and that stringent measures were needed to protect her and, per Mr Smith, the First Defendant had already apologised, by the time she died.

61. Mr Smith referred to 'triggers' identified in an initial Report, including changes to routine (such as a home visit) and over-stimulation (for someone with autism on an acute mental health ward). A multi-disciplinary meeting had said, as early as January 2017, that the Bradgate Unit was not a suitable setting. The Serious Incident Investigation Report was received by the Claimants' Solicitors in May 2017 and in June 2017 a Final Report to the Coroner concluded (at paragraph 240) that *'neglect was likely to have occurred.'* A letter of apology dated 20 October 2017 referred to an unacceptable failure to place Amanda on an appropriate level of supervision following her Christmas leave.

62. Hence, per Mr Smith, it was clear that Amanda should never have been on the Bradgate Unit, and that she should have had more supervision; however, given that the Claimants' Solicitors knew this prior to the first pre-Inquest review in December 2017, he asked the question, of what use and service was the pre-Inquest review, in terms of the civil claim? He further referred to the Council safeguarding team making findings of neglect; this was after the first but before the second pre-Inquest review. The Defendants accepted that they had failed to meet Amanda's needs and that the impact thereof contributed to Amanda's stress levels and, ultimately, to her death.

63. He assumed that the family had attended the Inquest (which is not in the Bill as the civil claim settled shortly before it took place) and stressed that it was entirely understandable and right that they would do so, but the fact that this was hugely important to the family, did not make it 'of use and service' in the civil claim. Amanda's condition and the risk it posed, were well known; the conditions on the Bradgate Unit must have been 'torture' for her and she was not watched properly (or as she had been promised she would be watched) but all of this was known. What more, of use and service to the proceedings, could be gained by in-person attendance? The sheer importance of the Inquest to the family, does not mean that it was of use and service as the *Gibson* test requires.

64. In conclusion, the Defendants assert that they resist all costs in their table (the table incorrectly totalled at £14,736.42 but in fact totalling £14,770.67) and state that neither a Solicitor/fee earner nor

a Barrister should have attended at the pre-Inquest review hearings (or, to put words into their mouths, if the Claimants wished to have representation at these hearings it is a matter for them/the Legal Aid Agency, and not the Defendants, to pay for).

Claimants' case on the Preliminary Issues –taken from the Points of Reply as elaborated upon by the Solicitor and Costs Lawyer at the hearing before me.

Point 4

65. As to Point 4, and again without repeating verbatim the contents of their Reply, the Claimants make several key submissions. Claims were brought pursuant to the Law Reform (Miscellaneous Provisions) Act 1934, the Fatal Accidents Act 1976 and the common law for negligence; and in addition pursuant to the Human Rights Act 1998 (regarding breaches to the European Convention on Human Rights at Articles 2, 3, 8 and 14) and the Equality Act 2010 – see below regarding pre-Inquest review costs.

66. The fact that the Claimants reside in Leicester is stated not to be determinative; the question is whether the instruction of Bhatt Murphy in London was an objectively reasonable choice by the Claimants, given all of the circumstances at the time; they, too, rely upon *Wraith* but also upon *Solutia UK Ltd v Griffiths* [2001] EWCA Civ 376. Here, the Claimants were referred to Bhatt Murphy by a charity (INQUEST) as a firm with experience and expertise in representing people whose loved ones have died in state care, being highly ranked for such work in Chambers and Partners and in the Legal 500. Given Amanda's death in such tragic circumstances, the Claimants' choice to instruct, *'a top human rights and civil liberties firm'* was, they say, a reasonable one. Any link between Bhatt Murphy and INQUEST is not material (to be fair to Mr Smith he did not lay great stress on this point in his own submissions and certainly did not suggest anything untoward behind INQUEST's recommendation).

67. At the hearing before me, Mr Buckley expressed doubt as to whether Duncan Lewis could have handled this matter; he also stated that Irwin Mitchell may have been able to do so, but that they would not have acted under Legal Aid. The test (he said) is not whether Bhatt Murphy were the cheapest option but whether the Claimants' choice of Solicitors was – objectively – a reasonable one.

68. Mr Buckley explained that Amanda's mother had got in touch with INQUEST after someone (a Police Officer working with the Coroner) had mentioned the charity to her; Mr Buckley took me to correspondence in which the Coroner also recommended the family might contact INQUEST.

Things were moving quite fast, the family wished to get representation for the pre-Inquest review which was less than two months ahead at that time. It needed expertise on death in Mental Health detention; pausing here, I am aware that sometimes Amanda was under Section and sometimes she was not. The simple fact is that her health was such that the family could not care for her at home. Whether she was 'detained' under Section or simply by circumstances beyond her or her family's control, matters not.

69. The family spoke to INQUEST by phone; Ms Phillips advised me that INQUEST have a database of firms around the country and work closely with firms across the country. Deaths in custody are not 'one size fits all' and they gave the recommendation that they gave; the case worker at INQUEST had done previous work on deaths in mental health custody and from that had knowledge of Bhatt Murphy.

70. Mr Buckley referred me to *Kai Surrey v Barnet and Chase Farm Hospitals NHS Trust* [2018] EWCA Civ 451 in which it was specified that the choice does not have to be the 'best' choice, it just has to be a 'reasonable' choice. The choice facing these litigants was (per Mr Buckley) reasonable in the circumstances with which they were faced; he referred in particular to the fact that there was a degree of urgency, the family knew that the Defendants were going to be represented and they wished to be represented and (in their grief) should not be criticised for 'failing' to shop around.

71. Mr Buckley referred me to *Wraith* and to the 'Seven Pillars of Wisdom' at CPR 44.3 (3) whereby the court (in assessing costs on the Standard Basis, as here) in considering whether costs are proportionate and reasonable in amount or were proportionately and reasonably incurred, will also have regard to –

(a) the conduct of all the parties, including in particular –
(i) conduct before, as well as during, the proceedings; and
(ii) the efforts made, if any, before and during the proceedings in order to try to resolve the dispute;
(b) the amount or value of any money or property involved;
(c) the importance of the matter to all the parties;
(d) the particular complexity of the matter or the difficulty or novelty of the questions raised;
(e) the skill, effort, specialised knowledge and responsibility involved;
(f) the time spent on the case;
(g) the place where and the circumstances in which work or any part of it was done; and

72. The Claimants rely upon the factors set out at CPR 44.3 in respect of Point 4 and Point 6; some of the detail therefore appears at Point 6 below. In my Judgment I have set out the most salient factors as I see them but assure the parties that I have carefully considered every relevant factor in relation to both Points 4 and 6.

73. As to skill and specialised knowledge, Mr Buckley asserted that Bhatt Murphy have a national reputation for this kind of case. In terms of the place and circumstances, Bhatt Murphy are in London 3 (Dalston and another location for a brief period at the beginning of the case) and Amanda's family, although in Leicester, were able and willing to travel to Bhatt Murphy in order to instruct them and take their advice.

74. As to hourly rates, regarding the amount or value of any money claimed, this case settled for £65,000 which is not insignificant, and in respect of which base costs (excluding VAT and costs of preparing and checking the Bill) of £137,258.22 are not disproportionate. I was told at the hearing that the figures at which the case was reasonably valued, were approximately:

    £12,500 - £15,000 in respect of the breach of Amanda's right to life (claimed on behalf of her Estate)
    £20,000 - £30,000 in respect of wider breaches/failures in care
    £5,000 - £10,000 by way of aggravated damages due to the 'blatant' failure to address these issues
    £15,000 - £20,000 each for Amanda's mother Jacqueline and father Michael, and £10,000 to £15,000 for her brother Simon in respect of their own Article 2 rights.

    Counsel's initial valuation was between £72,500 and £110,000 and as the case settled for £65,000 it settled at the lower end of the range but (per the Claimants) given that Amanda had been admitted as a suicide risk (or at least as someone whose 'cries for help' had brought her to very serious injury in the past), the ongoing failure to address and mitigate her ideations towards self-harm, specifically ligatures, was clearly an issue. In Mr Buckley's submission, nobody was surprised when the case settled early.

75. The Claimants deny that Counsel's involvement was such as to take the burden of the case onto his own shoulders and thereby deny the Solicitor acting (Ms Phillips) any significant entitlement to enhancement on her hourly rates (and to be fair, even the Defendants accept that some enhancement is called for upon her Grade A rate but not upon the Grade D fee earners' rates).

76. As to enhancement, the Claimants point out that the GHR would not be applicable to a case of this type; they were promulgated for Fast Track, slip and trip type cases and Amanda's death would not

be an appropriate case for their application. They refer to the GHR from 2010 (they have since been updated but were not when this matter was in progress, nor when it was heard) as being out of date and needing to be updated by reference to the Consumer Price Index. Just by doing that, they say, the Grade A hourly rate would come to £321, to which enhancement would then need to be applied in line with *Choudhury v Kingston Hospitals NHS Trust* [2006] EWHC 90057 (Costs).

Point 6

77. Turning to Point 6, for the Claimants, *Roach v The Home Office* [2009] EWHC 312 (QB) (para 60) and *Wilton v The Youth Justice Board and Another (Costs)* 23 December 2010 were relied upon; in the latter, Master Campbell held:

"I should not regard as my starting point 'what should it reasonably have cost to recover £30,000 in a death-in-custody case of this nature?' On the contrary, I accept Mr Westgate's submission that, having decided representation at the Inquest is in principle a reasonable item of cost, I should take into account in the overall arithmetic what a 30-day Inquest ought reasonably to cost and not just what was involved in the short-lived litigation about liability and quantum. In my opinion, the costs of preparing for and attending the Inquest fall within the global test under Lownds and whilst that does not mean that 100% will be recovered, a proportion will be, which is sufficient to counter the submission that this case was disproportionate because £250,000 was spent in order to recover £30,000. For these reasons I am not persuaded that the costs are or appear to be disproportionate, so the receiving party will need to satisfy the Court only that the costs have been reasonably but not necessarily incurred."

78. Pausing here, *Lownds* refers of course to *Home Office v Lownds* [2002] EWCA Civ 365 and is not the most helpful reference the Claimants could have cited given that the 'new' test under CPR Part 44.3(2) (a) specifies that costs which are disproportionate in amount may be disallowed or reduced even if they were reasonably <u>or necessarily</u> incurred. Be that as it may, the Claimants do rely upon Master Campbell's view as to £250,000 on an Inquest to recover £30,000, not being disproportionate, as support for their assertion that spending £14,736.42 (in fact, £14,770.67) excluding VAT on antecedent Inquest proceedings, cannot be said to be disproportionate in order to secure £65,000 as was the case here.

79. The Claimants aver that the *Gibson* test for recoverability of costs incidental to proceedings – proving of use and service in the action, relevant to an issue and attributable to the Defendants' conduct – has been supplemented by more recent case law, as follows. Firstly, they cite *The*

Bowbelle (Ross v Bowbelle (Owners) [1997] 2 Lloyd's Rep 196 in which Clarke J endorsed Master Hurst's decision that it was reasonable for the Steering Committee to attend the inquest through Counsel (notwithstanding a previous concession of negligence), in order to establish what *"pre-death pain and suffering had been endured by those who lost their lives".* Clarke J went on to state that, *"It follows that, unless there are particular costs which are not fairly referable to the attendance at the Inquest for that purpose, reasonable costs of the Inquest are in my judgment recoverable."*

80. The Claimants went on to refer to *Roach,* an Appeal from the SCCO, in which it was held that, *"It follows that, in agreement with the Cost Judges in each of these cases, I consider that the approach taken by Clarke J in the Bowbelle was correct. Costs of attendance at an inquest are not incapable of being recoverable as costs incidental to subsequent civil proceedings. Nor does this give rise to any unprincipled approach – because the relevant principles, as conveniently set out in Gibson, are available to be applied by Costs Judges in a way appropriate to the circumstances of each case."* Whilst the Claimants ended the quote there, it continues, *"It may also be remembered that Clarke J in fact disallowed some of the costs relating to the inquest claimed as costs incidental to the civil proceedings (the overall approach illustrating just how important the factor of relevance is). Mr Westgate in fact was, I think entitled to observe – as he did – that it was open in the instant case to the Home Office likewise to seek to avoid or minimise any potential liability for such costs here by admitting liability prior to the inquest. He and Mr Post were also entitled to observe that the inquests here in practice seem to have had the effect of causing the civil proceedings thereafter relatively speedily (and thereby in a way saving of some costs) to be compromised."* That seems to me to be a – potentially – helpful quote as well if (as I understand the Claimants wished me to do) I found that the Inquests, or rather the pre-Inquest reviews, were instrumental in the swift resolution of this matter.

81. The Claimants then quote Master Rowley in *Lynch* and again I cite here rather more of the relevant paragraph than they did; *"There have been a number of decisions at first instance by costs judges which have put these principles into practice. This decision is simply a further examination of a particular set of circumstances. The factor which takes this decision into seemingly uncharted waters is the issue of disclosure which took place prior to the inquest. The coming into force of The Coroners (Inquests) Rules 2013 on 25 July 2013 means that disclosure is now a regular part of the inquest process. That was not the case when the inquest to be considered here took place. It is not for me to lay down any form of general guidelines and the conclusions in this judgment relate to this case alone. But I appreciate that this issue may*

be of sufficient importance for the parties to take it further to seek authoritative guidance and that is, at least in part, why I decided to hand down a reserved judgment."

82. The Claimants' position is that *Lynch* represents the application by Master Rowley of the decided principles above to the facts in a specific case and they assert that his findings regarding pre-Inquest reviews and 'housekeeping' matters, set no new test: they were in respect of the facts in *Lynch* and do not govern what I may or may not do with this case. It is certainly correct to say that whilst I would regard any Judgment of Master (now Costs Judge) Rowley with great respect and may well find it persuasive, a decision at Costs Judge level is not binding upon me, and *Lynch* is such a decision.

83. The Claimants go on to refer to the Senior Costs Judge's decision in *Powell* in which, on the facts in that particular case, he decided that work corresponding with the Coroner or attending a pre-Inquest review, may be recoverable; it is a matter for detailed consideration, evaluation and discretion for the Judge in any given case. That is if you will the other side of the *Lynch* coin; a number of other cases at Costs Judge level were referred to in the hearing and whilst I am grateful to the parties for bringing them to my attention, I have not recited them all here. Both parties agree that the decision must turn upon the facts in the case before me, and the decisions of other Costs Judges on the facts in different cases, do not take the matter much further in my view.

84. Here, concerns surrounding the events leading to Amanda's death led to investigation and, in due course, an Inquest. At the hearing I was told that there was a lot of concern around Amanda's cause of death; there was a lack of clarity regarding her death as (when the family saw her in hospital) there were no tell-tale ligature marks around her neck, but also she had had been allowed access to a pot of a salt-like substance and there was therefore concern as to her sodium level as well as to her Fluoxetine level, so that toxicology evidence was in issue.

85. On receipt of the Claimants' instructions, steps were taken to obtain all disclosure from the Coroner, as well as the Serious Incident Investigation Report, received in May 2017 and thoroughly reviewed. The Claimants continued to obtain disclosure from the Coroner throughout June to August 2017, which included numerous handwritten records and Witness Statements, which were relevant and of use in the civil claim.

86. The first pre-Inquest review took place on 11 December 2017; matters regarding a Jury and Article 2 were discussed, both of which were highly important issues for the purposes of the claim against the Defendants. In particular, the Claimants wished to have an Inquest in front of a Jury so as to widen

the accountability aspect (their phrasing) and to widen the scope and obtain a narrative finding. An Article 2 disclosure duty was described as highly important as it would require the Coroner to take all reasonable steps to obtain and disclose to the Claimants any relevant evidence. This would in turn enable the Claimants to garner as much evidence as possible for a claim against the Defendants.

87. At the hearing I was told that there had been email correspondence to a 'safeguarding' address and the Coroner apparently expressed concern regarding gaps in the disclosure, there were questions regarding systems and practices e.g. recording and sharing of information about Amanda and its impact upon the quality of her care. Mr Desai (Counsel for the Claimants) pressed for Witness Statements and interviews, whereas the Defendants were resisting the production of documents due to confidentiality concerns. I was referred to the transcript for exchanges regarding Witnesses to be called, giving the Claimants an opportunity to challenge the care and placement issues around Amanda's final days. Mills and Reeve were challenging whether causation needed to be included but the Coroner agreed with the Claimants' submissions (via Mr Desai) that it would be useful.

88. The Claimants were trying to ensure that the Inquest scope covered matters relevant to the civil claim, as I was told at the hearing; one example being the involvement of a Consultant Psychiatrist with knowledge of large Mental Health Units like the one where Amanda died, and who also had knowledge of patients having Asperger's on top of other complex medical issues.

89. There were questions around (e.g.) whether it would be within a Nursing Expert's remit to speak to what a Psychiatrist tasked with Amanda's care 'ought' to have done, as well as questions around the crash team at the Bradgate Unit versus the West Midlands Ambulance first responders and what would and would not be covered, as well as CQC documents et cetera. I was referred to a transcript of the December 2017 pre-Inquest review which did not deal with 'housekeeping' but dealt with a great deal of detail; there is reference to Mr Simon Charlton of Browne Jacobson resisting widening the investigation and trying to limit the scope on behalf of the Defendants.

90. The matter was of massive importance to both parties; the Claimants had lost Amanda – avoidably – at a young age but the Defendants were being subjected to serious criticism and were astute to fight their own corner. At the December 2017 pre-Inquest review, 19 potential Witnesses were identified; by the end of the process there were due to be 39 live Witnesses plus a further 7 whose evidence was due to be read (I also heard reference to 50 Witnesses, which is a greater number than those two added together).

91. One example of the 'use and service' of the pre-Inquest reviews referred to at the hearing before me was that in a first Report dated February 2017, there was no detail on the issue of Amanda's placement; it was unclear who was ultimately responsible for the funding delays that led to Amanda being kept in an unsuitable setting for so long, and the fact that there had been a missed opportunity to move her, and that there had been discussions 'behind the scenes' about the Lighthouse Unit, where she might have been moved. This was only made known to the Claimants after Amanda died, by which time it was of course too late to save her. It had apparently been accepted fairly early that Amanda should not have been in the Bradgate Unit at all, but getting to the bottom of why she was there and who was responsible, took a great deal of digging (per the Claimants) at the pre-Inquest reviews.

92. Attendance at the pre-Inquest review then prompted further disclosure from all three Defendants. In addition, the parties were directed to provide written submissions for Expert evidence and disclosure, as well as provide all Statements and 'question and answer' interviews associated with the Serious Incident Investigation Report. Directions were also made for disclosure of Witness Statements and medical records, all of which were relevant for the purposes of gathering information and evidence for a claim against the Defendants.

93. In March 2018, submissions were made to the Coroner regarding Expert evidence, which would assist with liability for the civil claim, Dr Camden Smith (Psychiatrist) and Dr Stephen Edgeley (Nursing Expert) were instructed to consider issues around Amanda's treatment and care leading up to her death.

94. The matter was listed for a second pre-Inquest review on 30 May 2018; this focused on Jury, Article 2, scope, disclosure and Witness evidence. The relevance of a Jury and of Article 2 are said to be as before, with matters of disclosure and Witness evidence being useful for information and evidence gathering purposes, especially as regards the Defendants' liability. At the hearing I was told that there was a voluminous amount of evidence outstanding, and a hearing that had originally been set for March 2018, had been moved as there was material, which was clearly in existence and clearly relevant, but which had not been handed over. These gaps only came to light through the pre-Inquest reviews.

95. This was the case notwithstanding Rule 13 of the Inquests Rules which states that, subject to rule 15, where an interested person asks for disclosure of a document held by the Coroner, the Coroner must provide that document or a copy of that document or make the document available for inspection by that person as soon as is reasonably practicable. This is a provision relied upon by the Defendants but

if I have understood the position correctly, as at the second pre-Inquest review, the Coroner had not even seen much of the extant and relevant documentation, as the Defendants had not yet disclosed it. As such, citing a rule that would presuppose they had done what they were supposed to, when on the facts in this case they had not (or at least, not fully) would not assist the Defendants.

96. The disclosure comprised Witness Statements, handwritten notes, medical records, clinical notes, MDT (multi-disciplinary team) information sheets, care plan documents, SALT (speech and language therapy) documents, observations documents, incident reports, ward round reviews, assessments, test and examination results, Mental Health Act documents, PIER records, correspondence, discharge papers and Amanda's writings and drawings.

97. There were some 24,000 pages of data on Amanda's mobile phone; allowing for the fact that much of this would likely have been meta data and suchlike, the phone could have shed light on what Amanda had done herself to try to get help (e.g. reference was made to her texting carers; the phone might have shed light on whether 'Declan' was a real person etc.). The Claimants never saw all of it, and specifically there was reference to a Coroner's assistant making a Word search, which would not help with any audio or video clips etc. There was a great deal (15 lever arch files, 7,193 pages) of evidence even without the mobile phone; full disclosure to enable the Claimants to fully evaluate the claim (which is how the Defendants apparently worded it) was not forthcoming until October 2018, which was not only after both pre-Inquest reviews but was (in the Claimants' submission) only because of those reviews: per the Claimants, what came out at the pre-Inquest reviews enabled them to make targeted disclosure requests.

98. The written evidence is said to have been essential to determining the cause of Amanda's death and whether/to what extent the Defendants' failures contributed to her death. The Claimants assert that all the evidence obtained in the course of the Inquest proceedings was relevant and was used by the Claimants in the civil claim. Subsequent pre-action protocol correspondence and pleadings would all have referenced evidence gathered by the Inquest proceedings (I word it in that way because it is clear that the matter settled at an early stage and before the date on an extension of time for service of the Particulars of Claim, had even been reached).

99. All of it is described as work which it was entirely appropriate to undertake, and the costs incurred are said to be recoverable by reference to *Gibson* and *Bowbelle.* At the hearing I was also told that, with all due respect to the Coroner, there was concern around how evidence was being gathered (for example the 'wrong' question was put to a toxicologist; there was only an email – rather than a formal Report, I take it – from the pathologist regarding the salt-like substance to which Amanda had

access). There was a wealth of evidence to draw out, for example what was the role of the 'crash' team at the Bradgate Unit, given concerns around the CPR being performed upon Amanda at the time that the ambulance arrived. There were questions around who was responsible for what, especially as regards funding and placement.

100. The pre-Inquest reviews were attended only by the conducting fee earner and junior Counsel which is described as an appropriate level of resources and by no means a 'weighty' presence as the Defendants have described it. At the hearing my attention was drawn to the presence of teams from Browne Jacobson representing the First Defendant (three qualified lawyers), including Mr Simon Charlton, a Partner, Weightmans (representing the Second Defendant with again three qualified lawyers), Mills and Reeve (for the East Midlands Ambulance Service) and representatives for the Third Defendant, for the CQC and from Leicester County Council and the East Midlands Ambulance Service as well. The Claimants' legal team were outnumbered by a factor of more than five to one in terms of legal representation at the pre-Inquest reviews so that the reference to a fee earner and a senior Junior Barrister attending as a 'weighty' presence, does not seem apt.

101. Time spent in preparation for the pre-Inquest review hearings and the inquest, was all of direct relevance to the civil claim and assisted in achieving an early settlement; the settlement was in turn accompanied by full admissions of liability in respect of all causes of action, plus a letter of apology, plus a commitment to involve Amanda's family in training and/or learning lessons from Amanda's death. Again, these results (which were clearly very important to the Claimants although they did not involve any increase to the damages awarded) were achieved through preparation for the full Inquest and the pre-Inquest reviews.

102. In terms of the Defendants' conduct the Claimants noted that (in addition to the difficulties in obtaining disclosure, which was a drawn-out process) the first admissions of breach were made (in October 2017) only in respect of a lack of adequate supervision of Amanda from the time that she arrived back in the Bradgate Unit on Christmas Day, to the time that she was found, grievously injured, early on Boxing Day 2016. The Claimants were seeking much wider admissions and a meaningful apology for having failed Amanda by admitting her to an unsuitable setting, keeping her there for too long and failing to safeguard her from harm (whether self-inflicted or otherwise) during her time in the Bradgate Unit, coupled with assurances regarding future care for other vulnerable people in Amanda's position. During the hearing I was taken to correspondence from April 2017 in which it was made clear that justice for Amanda, declarations that her rights had been breached, and formal apologies (and recognition that lessons must be learned) were important to the Claimants along with damages.

103. Even so, the Defendants tried to avoid accountability and criticism, and to shut down issues that meant a lot to Amanda's family, including allegations of bullying. Amanda had made a video in which she discussed her treatment, and why it was not working, and I was taken (in the hearing) to correspondence regarding the Claimants' request that, to ensure that any apology was meaningful, it should be written into any settlement that this video should be shown to staff. A full admission was not forthcoming until November 2018 and (per the Claimants) the Defendants cannot rely on any earlier, partial admissions, to mitigate their liability for the costs involved in continuing to try to prove what they had not yet admitted, not least because the admission from November 2018 was worded to say that, in light of THIS admission, the matter should now proceed on quantum, condition and prognosis only.

104. The Claimants submitted that the Defendants did not fully understand the claim; it was not (as the Points of Dispute suggest) a Clinical Negligence matter, claims were brought pursuant to the Law Reform (Miscellaneous Provisions) Act 1934, the Fatal Accidents Act 1976 and the common law for negligence; and in addition claims pursuant to the Human Rights Act 1998 (regarding breaches to the European Convention on Human Rights at Article 2 – right to life, Article 3 – absolute right not to be tortured or treated in an inhuman or degrading manner, Article 8 – right to privacy and Article 14 – rights and freedoms to be protected and applied without discrimination) and the Equality Act 2010 regarding disability discrimination.

105. Thus, for example, an early admission made only in respect of the lack of supervision between Amanda's return to the ward on Christmas day and her being found grievously injured early on Boxing Day 2016, would (if, absent the pre-Inquest reviews, it had rested there) have impacted upon her Human Rights claims as the extent of her suffering attributable to the Defendants' breach would be much lower if it was only for those last few hours. Likewise, the broader failings in Amanda's care enabled the matter to be framed as a Disability Rights matter, but only because the Claimants refused to accept an apology for a few hours right at the end of Amanda's life; the situation throughout 2016 and the build-up over a long time, possibly as far back as 2014 but certainly for several months leading up to her death, were kept in focus only because the Claimants pushed back on those issues.

106. At the hearing I was told that the Equality Act claim, based on the serious and prolonged nature of the Defendants' breaches and their impact on her, was worth approximately £38,500 but was very difficult to prove in terms of how much of Amanda's suffering was due to the circumstances and how much was due to her own evidently very poor pre-existing mental state.

Aggravated damages were called into play by what I was told were 'blatant' examples of ignoring Amanda's needs and her autism. Earlier ligature incidents were not addressed and failures to make reasonable adjustments or to mitigate, led to breaches that were not only breaches of the Defendants' duty of care towards Amanda in negligence, but also to breaches of Amanda's Article 2 and Article 3 rights and to her rights under the Equality Act by reason of those failures.

107. A full admission was not received until November 2018, after the pre-Inquest reviews had already taken place, hence authorities regarding admissions pre-Inquest did not assist the Defendants. The initial Investigation Report purported to clear the Third Defendant of delay; hence, even with an admission of liability (but only from the Trust in respect of the care Amanda was receiving, and not from the Third Defendant in respect of not getting a suitable placement for Amanda in time to save her life) the initial offer was for half the amount at which the claim ultimately settled. The Claimants were in addition concerned to address the systemic failures in Amanda's care; as previously canvassed, it was not just about the damages and the Claimants were prepared to hold out, not for more money but for admissions, an apology and a commitment to learning from Amanda's case.

108. The Claimants submit that the Defendants' provision of a list of cases (see above) for the Court's perusal, is not helpful and I do see the force in that submission. Given that the question of whether Inquest (or pre-Inquest review) costs are recoverable between the parties, seems to be entirely fact-specific in each case, I do not know how much those other cases might have helped, and have indeed specifically omitted a number of other Costs Judges' decisions for that very reason, but simply supplying a list of cases is not optimal and has not assisted me (or the Defendants).

109. In conclusion, the Claimants refer to *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2, on the importance of ascertaining the precise nature of the Defendants' breaches of Amanda's right to life under Article 2 and/or of their duty of care towards her, it was essential to represent the Claimants in the lead up to the Inquest in order to identify and inform the nature of those breaches. As a result of the evidence gathered from the Inquest proceedings and inextricably linked pre-Inquest reviews, the matter was capable of early settlement ahead of the Inquest. As such, per the Claimants, all the costs are recoverable with reference to the principles outlined above and the costs claimed are proportionate.

Preliminary Issues – Court's ruling

110. I appreciate I have set out the facts in quite a lot of detail, but the reason for that, is that these decisions are so fact specific. I have been referred to a number of other cases at Costs Judge level,

but none of them have the same factual matrix as this case. I have not given page references, but during the hearing I was taken to every transcript, every item of correspondence and every attendance note relied upon by the Claimants and to be clear these are contemporaneous records of what was happening during the case and I found what I was shown to be both accurate and very persuasive.

111. In fairness to Mr Smith, he did not challenge this evidence and whilst he put the Defendants' case as highly as he properly could, he also accepted that the Claimants' actions and choices in this matter were entirely understandable, his challenge was simply as to whether those actions and choices should be visited upon the Defendants in costs. The short answer is yes, they should, and this is for the following reasons.

Point 4 Hourly Rates

112. As to Point 4, hourly rates, I find first of all that it was objectively reasonable for the Claimants to instruct Bhatt Murphy. The firm has a national reputation for this kind of work and was recommended to the Claimants by INQUEST. I do not find the fact that Mr Bhatt of Bhatt Murphy is a force behind INQUEST to be troubling on the facts in this case; there are many interest groups, pressure groups and charities working with different kinds of litigants (Defendant as well as Claimant groups) and the fact that a high-profile firm or Solicitor has close ties to one such group, is of no concern here. INQUEST maintains a database of expert lawyers for such cases; they recommended Bhatt Murphy, and that recommendation is a fact upon which the Claimants are entitled to rely in accordance with the principles in *Wraith.*

113. The Defendants suggested that a number of other firms, including Duncan Lewis and Irwin Mitchell, could have handled this 'Clinical Negligence' matter. The problem with that is that this is not a Clinical Negligence claim and there are issues involving Human Rights and the Equality Act/disability discrimination. Most significant of all, this is a case involving a death in mental health custody (and I reiterate, whether Amanda was being 'held' under Section is not determinative in any way, on the facts it was not safe for her to come home for more than a short time).

114. This is a specialised area of the law; Mr Buckley asserted that Irwin Mitchell would not run the case with Legal Aid in place (although in fairness I had no evidence on that point) and that highlights just one aspect of the specialised nature of this work. The way in which Legal Aid 'abuts' the CFAs in such cases is not common knowledge and the ability of a specialised firm to ensure that

the Claimants were able to attend the Inquest proceedings without fear of the cost thereof, is just one factor in why the choice of firm is objectively reasonable.

115. The lack of evidence also cuts both ways; even if Mr Smith is right, and Duncan Lewis or Irwin Mitchell could have run this case (and bearing in mind we are going back to 2017/18, whatever capacity they have now, their capacity then would be the relevant issue) I have seen nothing to suggest that they would have run this case at a lower hourly rate than that charged by Bhatt Murphy.

116. Taking Irwin Mitchell, for example, they have offices in Sheffield and to their credit when work is done in Sheffield, they apply rates lower than the rates for work done out of their London offices. However, they are a specialist firm and they do not tend to charge GHR for their services; sometimes they recover rates very substantially in excess of GHR, depending upon the type of case. Had they been approached by the Claimants in such a tragic and high-profile case, it is foreseeable that they might have decided that it warranted one of their London-based Solicitors, and even if they ran it from a regional office, it is in my view certain that their hourly rate for such work would have been substantially in excess of GHR and may have equalled Bhatt Murphy's London 3 rate.

117. Mr Smith recognised that the GHR for London 3 are not so very different from the GHR for National 2, but to be clear that again feeds into the objective reasonableness of the Claimants' choice. If this was a case to which GHR applied – and with the death of a vulnerable young woman in the Defendants' care this was never going to be such a case – the locality of Bhatt Murphy would make very little difference as far as hourly rates are concerned.

118. The Defendants have been represented by law firms well-versed in defending claims against NHS Trusts and the like. If anyone would be in a position to produce evidence of lower hourly rates in the Midlands for such work, it would be the Defendants, and no such evidence was produced by them. In the absence of any evidence that a 'local' firm existed with the resources to run this case to the standard provided by Bhatt Murphy, for less per hour than Bhatt Murphy were charging, I find that the location of Bhatt Murphy does not diminish the reasonableness of the Claimants' choice.

119. I also accept the Claimants' submissions on the 'Seven Pillars of Wisdom' and in particular, as well as the skill and expertise above referred to, which is key on the facts in this case, I note that conduct has been another such factor. Mr Buckley did not suggest, and I do not find that the Defendants' legal representatives have been guilty of any misconduct. They are entitled to mount a robust defence and on my reading of the facts that is exactly what they did, although they capitulated once the writing was on the wall. However, their robust defence and sheer weight of numbers (the

listing of Defence personnel at the pre-Inquest reviews took several minutes just to read into the record) does have an impact upon the reasonableness of the Claimants' choice in choosing a firm that would be content to attend with just one fee earner and one Barrister in the face of such opposition.

120. As to the efforts made, if any, before and during the proceedings in order to try to resolve the dispute, whilst I accept that Mr Smith was endeavouring to assist the Court with truthful and correct submissions, I am afraid that his instructions (and the Points of Dispute, which will have fettered his submissions more than somewhat) were, on this issue, incorrect. Much was made of the early 'admission' by the Defendants in this matter but in fact it was very limited, both as to its scope (a few hours around the time that Amanda's life ended) and as to who was making the admission (not all three Defendants). In order for the Claimants to establish the full extent of Amanda's suffering and of the Defendants' failings, they had to press on with the pre-Inquest reviews and only received a full admission (and apology) from all three Defendants at a much later date, after those took place.

121. As to the amount or value of any money or property involved, that was not the main focus of either party; at £65,000 the matter clearly settled at a figure much higher than (say) statutory bereavement damages and the cost of a decent funeral. I accept that the Human Rights and Equality Act issues were significant factors in the settlement figure achieved, and in that respect, the instruction of Bhatt Murphy was a decisive factor in running this claim to a successful conclusion.

122. Value was clearly outweighed by the importance of the matter to all the parties; this was not just a factor for the Claimants, who had lost their loved one in the most tragic circumstances and were keen to ensure that Amanda's death should mean something, not simply in terms of damages but in terms of lessons learned that could help to protect other vulnerable people in the same position. There was also a high degree of importance to the Defendants, which can be illustrated by just one example.

123. In his submissions, Mr Smith referred to the fact that conditions in the Bradgate Unit must have been 'torture' for Amanda, and that this was 'known' (I am paraphrasing a submission made by him in regard to the claim for pre-Inquest review costs). With all due respect to Mr Smith, that was not a point that assisted the Defendants; I accept that, ultimately, the matter was resolved with the Claimants' agreement, but during the currency of the dispute the Defendants tried to keep matters within very close parameters especially as to the timeline. The idea that they would not be motivated to deny or at least to delay admitting, that Amanda's living conditions must have been 'torture' for her, is simply not persuasive. They attended the Inquest in force of numbers and fought as hard as

they could for as long as they could. The hourly rates charged by Bhatt Murphy have to be viewed against that background of very robust litigation by several leading Defendant firms.

124. As to the particular complexity of the matter or the difficulty or novelty of the questions raised; without repeating all of the facts set out above this was very clearly a complex and difficult matter. There were multiple failures across many months (or years), there was a vast amount of documentation and there were numerous causes of action against three Defendants. Even after the matter settled, the Points of Dispute referred to this as a Clinical Negligence matter with no reference to the Human Rights or Equality Act issues which were (as I have found) both of great significance to the Claimants in terms of what had happened to Amanda, and of importance in terms of the level of damages awarded to the Claimants which included substantial elements of non-negligence damages.

125. The time spent on the case is not a factor of which either party made a great deal, but on the place where and the circumstances in which work or any part of it was done, I note Mr Buckley's submissions as to the specialised and challenging nature of proceedings before a Coroner's Court and I accept that this is yet another factor that affirms the choice of Bhatt Murphy to run this case.

126. All of these factors also affect not only the choice of Bhatt Murphy but the rates charged by that firm. I was assisted by learned submissions from Mr Smith and from Mr Buckley on how I should proceed to calculate a reasonable and proportionate hourly rate. The old A plus B factor calculations of *Johnson v Reed Corrugated* et al are no longer the fashionable choice but they do allow me to take a view and then cross-check the figure reached against some established principles.

127. With regards to the submission that, for work done in 2017 and 2018, inflation is not something that I should take into account; I note that the Master of the Rolls thought the rates were, if anything, too high in 2014. However, over time it became clear that the 2010 GHR were no longer fit for purpose. In a case involving General Management in the Court of Protection, which is not work of the same order of complexity as this case, and which warrants GHR as this case does not, in *PLK and Others (Costs)* [2020] EWHC B28 (Costs), Costs Judge Whalan said Judges should apply: "*some broad, pragmatic flexibility"* when applying the 2010 GHR during the period from 1 January 2018 onwards and that "*if the rates claimed fall within approximately 120% of the GHR they should be regarded as prima facie reasonable."*

128. A *PLK* uplift on £267/hour (top end London 3 Grade A rate) would bring it to just over £320/hour without any enhancement whatsoever. Given the factors above referred to, I would be

prepared to enhance the hourly rate above that amount. Bearing in mind my own knowledge of the rates charged in the legal services market for specialised work of this sort and doing the best that I can, I find that the hourly rate claimed in the Bill for time spent/work done by for Ms Phillips is reasonable as claimed at £350/hour. Applying *PLK* alone, would result in an hourly rate of £145 for Grade D London 3, and for that reason I uphold the £140/hour claimed even though for Grade D work I would not have allowed any enhancement. As for the Costs Consultant, this is specialised work meriting more than the GHR for Grade D London 3 and I find that £150/hour is also a reasonable rate, which I uphold.

Fee Earner	London 3 GHR	C Rates claimed	D Rates offered	Allowed
Ms Phillips Grade A	229.00-267.00	350.00	225.00	**350.00**
Ms Solopova Grade D	121.00	140.00	111.00	**140.00**
Mr Ferdinand Grade D	121.00	140.00	111.00	**140.00**
Ms Carini Grade D	121.00	140.00	111.00	**140.00**
Ms Lisette Grade D	121.00	140.00	111.00	**140.00**
Costs consultant	121.00	150.00	111.00	**150.00**

Point 6

129. At the hearing before me, the judgment in *Fullick* was referred to by both sides; Mr Buckley, Costs Lawyer for the Claimants in this case also appeared for the Claimants in *Fullick* and the case was a recent decision in the High Court (and therefore potentially binding rather than merely persuasive) dealing with the question of whether the costs of attending an Inquest are recoverable in cases where the claimant has succeeded in a claim following death.

130. Slade J in *Fullick* reinforces the fact that the costs of attending an Inquest are potentially recoverable in a claim for damages following the death, but that the Court has to be careful to ensure that the costs allowed are those that are reasonably necessary (and proportionate) in the pursuit of the civil claim, which must be decided upon consideration of the Bill of Costs. Here, I have what would at the time have been a relatively early electronic Bill, which has sufficient detail to enable me to assess whether the sums claimed do indeed relate to investigation of the civil claim, especially as assisted by the learned submissions of the advocates who attended before me.

131. *Fullick* also reminds the reader that Proportionality does not just relate to the sums of money involved; in cases such as this one, finding out what caused such a death is a very significant factor

as well. Due to her various health issues, Amanda did not have and may never have had any prospect of a career, let alone a high-earning one. Nor was she in a relationship (not counting 'Declan' who may or may not have existed) and nor had she had any children. Those facts close off a great many potential heads of loss, but that does not mean that Amanda's life was not worth anything nor that her life was not worth more than £65,000.

132. Obviously, it was, but on the facts in this case I would say that, as important to the Claimants as the money damages, was finding out exactly what happened to Amanda and why so as (hopefully) to avoid the same sad fate befalling any other vulnerable people in a similar position. This is borne out by the fact that the Claimants did not accept the £65,000 settlement figure the moment it was offered, but held out, not for more money but for a meaningful apology and a commitment to take lessons from Amanda's death, to benefit other vulnerable young people in Amanda's position.

133. It is notable that in *Fullick* the action settled without service of a letter of claim or particulars of claim, for £17,000 and the Claimants' Bill of costs totalled £122,000, to include the costs of attending two pre-Inquest hearings. Deputy Master Keens allowed the costs of attending those hearings and the Defendant appealed on the grounds (inter alia) that costs of attending the Inquest should not be recoverable at all. Mrs Justice Slade, after duly considering the competing arguments, found that Deputy Master Keens, *"did not err in his conclusion that the costs attendance at the Inquest hearing were reasonably and proportionately incurred. The cause of death and recommendations for changes in police procedure were relevant to the civil claim. The claim was for damages for breaches of Article 2 of the European Convention on Human Rights in relation to the death of Ms Jones at a police station. Evidence on the cause of death and actions and procedures of the police given in the Inquest and the verdict reached are relevant to those issues. Consideration should be given to whether all or only some of the steps in the Inquest proceedings are relevant to the civil claim. If they are, whether the costs incurred in participation by the Claimant in each of those steps is proportionate and reasonable. If some of those steps are agreed, such as the giving of certain evidence, it is unlikely to be proportionate or reasonable for a receiving party to attend a pre-hearing review to deal with agreed matters."*

134. If one substitutes, 'Amanda' for 'Ms. Jones', 'following a ligature on the Bradgate Unit' for 'at a Police Station' and 'the Defendants' for 'the Police' the above quote could apply to this case; notably of course this case dealt with pre-Inquest reviews rather than an Inquest 'proper' but equally notably, there was not much in the way of 'agreed matters' as far as I have seen. As in *Fullick* and unlike *Kazakhstan Kagazy,* the civil claim in Amanda's case was about much more than money. It challenged the Defendants' systems and practices and asserted multiple breaches not only of the

Defendants' duty of care in negligence but of the European Convention on Human Rights as well as the Equality Act. Without repeating all of the facts there were concerns around keeping a young person with autism on the Bradgate Unit which Mr Smith rightly accepted must have been 'torture' for her, concerns around bullying, safeguarding, concerns around a young woman reporting rape and nothing being done about it, concern around a young woman ligaturing to the point of unconsciousness and no Serious Incident Report being made, concern about Amanda having access to a salt-like substance and so on.

135. There were unanswered questions about why it had taken so long to recognise that Amanda needed to be moved from the Bradgate Unit, to seek or obtain funding for such a move and as to whose responsibility it was to seek and obtain such funding. There was even doubt as to Amanda's cause of death, given the lack of tell-tale ligature marks and the availability of other potentially harmful substances which should not have been within reach of someone with her history of self-harm. There was so much more going on than simply a lack of level 1B supervision for a few hours upon her return on Christmas day; the situation was untenable, and this had gone on for months if not years.

136. The question of whether the costs of the items in the Defendants' table (at Point 6 in the Points of Dispute) should be allowed at all is different from the issue of whether the amounts claimed in respect of them is proportionate and reasonable; the Point of Dispute as drawn seeks to disallow all of these costs and make no offers in respect of any of them. In my judgement, the pre-Inquest reviews were of very significant use and benefit in the civil claim, both in respect of the issues referred to above (as to the treatment received by Amanda and its impact on the non-negligence aspects of the Claimants' claim) and in respect of disclosure.

137. Without having been more than robust as they are entitled to be (and, as guardians of the public purse, the public would expect them to be) the Defendants were trying to limit the scope of what the Coroner would be looking at and therefore to limit the disclosure available to the Coroner and hence to the Claimants. That again made the pre-Inquest reviews of significant use and benefit in the civil claim because, in plain terms, but for their representation at those pre-Inquest reviews, the weighty presence of Defendant lawyers may have prevailed upon the Coroner and key documents and facts might never have come to the fore.

138. I find that these costs are in principle recoverable. They are relevant to issues in the civil claim so as to be recoverable as costs in that claim, and I have set out above the identification of outstanding issues necessary to the civil claim in respect of which the Claimants' case would be

advanced by participation in the Inquest, and what it was in that participation which would assist with the civil claim. Weighing the value of that assistance against the cost of pursuing that particular point in the Inquest, I also take the view that they are at first blush proportionate.

139. It is a matter for the parties as to how much more time they would wish to devote to the necessary exercise (as Slade J found it to be in Fullick) of identifying and evaluating the relevance and utility to the civil claim of participating in the various items in the table at Point 6.

140. I find that it was reasonable, proportionate and of use and benefit to the civil claim to attend and therefore to prepare for (and to travel to) the pre-Inquest review Hearings, and that it was reasonable for Ms. Phillips and Mr Desai both to attend. If the Defendants believe that more may be achieved in terms of reducing the £14,770.67, than it will cost to do so, by taking me to any specific items at a future line-item Assessment I will consider the position – the Claimants may say that the 'holding' General Point 1 is not sufficient to allow such an approach. I would certainly question whether it is worth going through (e.g.) the transcripts of the pre-Inquest reviews to try to isolate odd bits of 'housekeeping' (if any) that could be excluded here and there; the 'High level' decision is that the pre-Inquest review costs are, broadly speaking, recoverable on the facts in this case.

141. I would add that whilst the use of hyperbole is a viable tool in rhetoric, the Defendants' reference to 'eye-watering' costs at Point 6 is misplaced. Amanda died after months of inadequate care, culminating in her taking steps that ended her life (I do not say taking her own life because it is far from clear that she intended it to go as far as that) at the young age of twenty.

142. In the context of the Claimants' wish to get to the bottom of why such a vulnerable young person who had been making multiple 'cries for help' over the preceding months and years, and who seemed, based upon the background facts, to have had a reasonably clear pattern of harming herself at the first opportunity if her supervision levels should fall, had been put on such a low level of supervision hours before she died, I do not regard the costs as 'eye-watering' at all.

143. To end on a more positive point, I have made several references to Mr Smith acknowledging this or accepting that. To be clear, the advocates on both sides advanced their respective clients' cases to the best of their ability and Mr Smith took every point that he was able to take. Where there were points that he did not press, that was in the performance of his overriding duty to assist the Court and I am most grateful to him and to Mr Buckley (and Ms Phillips) for their submissions.

144. If the remainder of this matter does not settle, I can list it fairly soon; I will hand this Judgment down on 9 June 2023 but nobody need attend on that date.