



Neutral Citation Number: [2024] EWHC 2809 (KB)

Case No: QB-2021-000606

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 07/11/2024

Before :

HIS HONOUR JUDGE AMBROSE

(sitting as a Judge of the High Court)

Between :

Ms WILMA AGNES CULLEN

Claimant

- and -

Dr RUTH HENNIKER-MAJOR

Defendant

Christopher Hough (instructed by **Leigh Day Solicitors**) for the **Claimant**
Farrah Mauladad KC and William Wraight (instructed by **Kennedys Solicitors**) for the
Defendant

Hearing dates: 1, 4, 5, 6, 7, 8 March 2024, 21 June 2024, 2 July 2024, 19 July 2024

Approved Judgment

This judgment was handed down remotely at 10.30am on 7 November 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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His Honour Judge Ambrose sitting as a Judge of the High Court:**INTRODUCTION**

1. This is a clinical negligence claim arising out of a negligently delayed diagnosis of laryngeal cancer, resulting in more extensive treatment for the cancer than would otherwise have been required and, in particular, leading to total laryngectomy. The Claimant now breathes through a stoma in her neck and speaks via a valve located in the wall between her trachea and oesophagus.
2. Liability has been admitted and judgment entered in the following terms: “That there was a failure by the Defendant to refer the Claimant for investigation of her symptoms on an urgent basis on 18 January 2016; that if the referral had been made, the Claimant’s cancer would have been diagnosed at an earlier stage; that the Claimant would have been treated with less radiotherapy and that no chemotherapy would have been required; that the total laryngectomy and bilateral neck dissections and severe complications of the chemotherapy would have been avoided.”
3. The outstanding issues are the quantification of the claim and, following a late amendment to the Counter-Schedule, allegations of fundamental dishonesty.
4. So far as quantification of the claim is concerned, the parties have reached agreement on many of the heads of claim:-

Head of claim	Agreed/To be determined
General damages	£100,000
Interest	£TBD
Past losses	
Care	£TBD
Travel	£2,500
Equipment	£6,439
Interest	£TBD
Future losses	
Care	£TBD
Case management	£TBD
Carers’ holiday costs	£TBD
Physiotherapy	£8,580
Psychological treatment	£TBD
Speech and language therapy	£32,000
Equipment	£TBD

5. The remaining items in dispute are past and future care (including case management and carers’ holiday costs), future psychological treatment costs and future equipment costs. Of these, past and future care are by far the most substantial and contentious aspects of the claim. The Claimant’s case is that she has needed, and will continue to need in the future, care and assistance in managing her stoma/airway and her voice valve. Her needs are intermittent and unpredictable and she needs someone on hand to assist her as and when required, which for practical purposes means she needs, and has had, someone on hand on a 24 hour basis. Her past and future care claims are advanced on this basis. In fact, due to a large part of the Claimant’s past care needs having been

met by first her local authority and then NHS funding, her past care claim is limited to the additional gratuitous care provided by family and friends. Her future care claim is advanced on the basis that her future care will be privately-funded. The Claimant's care expert has proposed a number of models for that care. The Defendant denies that the Claimant needs care on a 24 hour basis and does not admit that the past care and assistance claimed has actually been provided. The Defendant denies the need for future care as claimed. Some of this challenge is bound up with the Defendant's allegations of fundamental dishonesty. In closing, the Defendant conceded that if the court finds the Claimant to be honest, the Defendant concedes 24 hour care as the basis for the future care claim, but disputes the model advanced by the Claimant for such future care. The Defendant's care expert recommends an alternative model. So far as future psychological treatment costs and future equipment costs are concerned, the parties are not very far apart, but they are not agreed. The relevant experts have not been called to give oral evidence and I must make my determination on the basis of their reports.

6. So far as the allegations of fundamental dishonesty are concerned, they were pleaded in detail in the Amended Counter-Schedule and remain unaltered in the Re-Amended Counter-Schedule, served after the close of the evidence. They are, in the order they are pleaded, as follows:-
 - i) It is alleged that the Claimant has been changing her voice valve herself since December 2022 and, since the Claimant claims to be unable to manage the valve herself, her failure to declare that she is able to do so is dishonest and has resulted in a grossly over-inflated claim for future care. When the application to amend to plead fundamental dishonesty was first made, this was the flagship allegation. It has not been withdrawn. In closing submissions, but not by way of amended pleading, the Defendant sought to put a gloss on it, alleging that the Claimant can perform some, but not all, of the actions required for a valve change and alleging that she has failed to disclose this partial capacity and that amounts to dishonesty.
 - ii) It is alleged that the Claimant was dishonest in relation to her funded care and the payment of carers during the first Covid lockdown in 2020.
 - iii) It is alleged that the Claimant was dishonest in relation to her funded care and the payment of carers during periods when she was away on holiday.
 - iv) It is alleged that the Claimant has been dishonest in her claim that she receives care and assistance on a 24 hour basis. The Defendant relies upon surveillance evidence in support of this allegation.
 - v) It is alleged that the Claimant has made a dishonest claim for a stairlift.
 - vi) It is alleged that the Claimant has been dishonest in her presentation of her loss of amenity, in particular her social life. The Defendant relies on social media posts in support of this allegation.

The evidence

7. The evidence in this case is voluminous. The trial bundles comprise a total of 25 lever arch files. At trial I heard evidence over 8 days (1, 4, 5, 6, 7, 8 March 2024, 21 June 2024 and 2 July 2024) and the transcript of that evidence runs to 669 pages (with each page containing 4 pages of transcript). Following the close of the evidence, written closing submissions were provided on 16 July 2024 and oral closing submissions were heard on 19 July 2024. Supplementary (unsolicited) written closing submissions were received from the Defendant on 3 October 2024 and the Claimant responded on 4 October 2024.
8. On behalf of the Claimant, I heard oral evidence from Wilma Cullen (the Claimant), Anna Crowley (friend and carer), Dayne Cullen (son and carer) and Danny Cullen (son and carer). I also received a witness statement from Lindsay Lovell (treating speech and language therapist ('SLT')). I heard oral expert evidence from Professor Jarrod Homer (ENT), Ms Samantha Holmes (SLT) and Mrs Helen Howison (care). I received written expert reports from Dr David Evans (respiratory medicine), Professor R Symonds (oncology), Dr Kari Carstairs (clinical psychology) and Ms Ruth Ainley (respiratory physiotherapy).
9. On behalf of the Defendant, there was no oral lay evidence. There was, however, surveillance footage and a witness statement from Freya Sparks (another of the treating SLTs). I heard oral expert evidence from Ms Kate Heathcote (ENT), Mr Mark Williams (SLT) and Ms Marie Palmer (care). I received written expert reports from Professor Neil Barnes (respiratory medicine), Dr Jenny McGillion (clinical psychology) and Ms Holly Spencer (physiotherapy).
10. In reaching my conclusions, I have considered the whole of the evidence in the case. However it is neither possible nor desirable to set out in this judgment an exhaustive review of every piece of evidence or to deal with every point that has been raised. When deciding what to include in my judgment, I have made a selection based on my assessment of importance and relevance to the issues that I have to determine.

Structure of the judgment

11. As will be apparent from the above introduction, this is a case that has been fought on several different fronts. It would be unwieldy and confusing to try and address all those fronts together. I have therefore structured this judgment so as to deal with them separately. However I emphasise that in reaching a conclusion about one aspect of the case, I have considered not only the evidence that relates directly to that aspect, but I have also had regard to the wider evidence in the case and the extent to which it helps to shed light on the particular aspect under consideration. I do not propose to reiterate this approach alongside each finding that I make, but my judgment should be read with this in mind.
12. The central issues in the case relate to the management of the Claimant's stoma and voice prosthesis. Her claims for past and future care depend on the extent to which she needs assistance managing them. The Defendant's allegations (i) and (iv) of fundamental dishonesty are allegations that relate directly to her need for assistance managing them. It is therefore convenient to start by considering the evidence in

relation to the management of her stoma and voice valve and to make findings about that evidence.

13. I shall then turn to the allegations of fundamental dishonesty. They relate to a number of different aspects of the evidence and it is convenient to deal with them separately.
14. I shall then turn to quantification of the claim.

MANAGEMENT OF THE CLAIMANT'S STOMA/AIRWAY AND VOICE VALVE

15. In the evidence, and therefore also in this judgment, the terms stoma and airway have often been used interchangeably, as have the terms voice prosthesis and voice valve.

Background

16. I start with a brief summary of the Claimant's cancer diagnosis and treatment. The Claimant was born on 9 September 1957. She has a long history of smoking. She suffers from chronic obstructive pulmonary disease (COPD). In December 2014, she attended her GP practice with a cough and sore throat. She re-attended her GP practice in August 2015 complaining of tiredness, wheeze and a sore throat. Between August 2015 and 16 March 2016, there were numerous attendances at her GP practice complaining of continuing and worsening symptoms. Latterly she was seen by the Defendant GP on three consecutive occasions on 14 December 2015, 4 January 2016 and 18 January 2016. On none of these occasions was a 2 week wait cancer referral made. There were further telephone consultations with a different GP in February and March before she was asked to attend the practice on 16 March 2016, when a 2-week wait cancer referral was made to the ENT department at the Royal London Hospital.
17. She was seen at the Royal London Hospital on 30 March 2016, and a possible diagnosis of supraglottic squamous cell carcinoma was made. A CT scan and debulking biopsy were arranged. The CT scan took place on 15 April 2016 and showed a large supraglottic/glottic tumour. The debulking biopsy took place on 25 April 2016 and confirmed that she had Stage III supraglottic laryngeal cancer.
18. She underwent a course of chemoradiotherapy at St Bartholomew's Hospital beginning in June 2016 and concluding on 31 July 2016. It involved 42 sessions of radiotherapy with chemotherapy at the beginning and end.
19. A CT scan in November 2016 showed no residual disease following this treatment. However an MRI scan in early 2017 showed possible recurrence of the cancer, requiring further investigation. She underwent a micro laryngoscopy and laser debulking, requiring ITU admission post operatively. A further micro laryngoscopy was carried out in June 2017, following which she suffered respiratory failure and required ITU admission for several days. Fortunately the tissue specimens taken during these procedures did not demonstrate the presence of cancer.
20. However, the side-effects of her treatment and the laser debulking left the Claimant with an incompetent larynx. In order to restore her ability to eat and drink, and avoid being fed long-term via a tube, on 18 July 2017 she underwent a total laryngectomy with bilateral selective neck dissection (levels 2, 3, 4) and left pectoralis major reconstruction.

21. Post-operatively she had significant tissue breakdown and fistula formation which had a fairly catastrophic effect on her. She had a prolonged and stormy post-operative stay and had to return to theatre on 28 July 2017 for further surgery, namely an open neck exploration with debridement of necrotic tissues, repair of pharyngeal defect, re-suturing of pectoralis major flap and insertion of a salivary bypass tube (in effect an internal stent). This ultimately worked, with eventual wound healing. She remained in hospital for a further three weeks, before being discharged home on 17 August 2017 with a feeding tube in situ. She underwent a further operation on 1 September 2017 to remove the salivary bypass tube. Her feeding tube was removed at a later date.

Factual evidence relating to stoma/airway and voice valve management

22. It is convenient to consider the evidence (broadly) chronologically.
23. In her witness statement dated 18 May 2023, the Claimant described her experience of undergoing chemo and radiotherapy in June 2016. There were two whole day sessions of chemotherapy at the beginning and end of the radiotherapy which lasted for 42 sessions, Monday to Friday over many weeks. The effects of the radiotherapy were considerable. She felt drained and very lethargic, she vomited a great deal and went off her food. She had terrible ringing in her ears. She was accompanied to her appointments and she needed support once she got home. This was mainly provided by Dayne Cullen, although Danny Cullen and other family members also assisted.
24. After the end of her chemo and radiotherapy, the Claimant gradually got better but then she began to develop problems with her voice and with eating and drinking. Her consultant told her that although the treatment had worked well on the cancer, it had damaged her voice box and epiglottis. In January 2017 she underwent a procedure to debulk her throat and remove her epiglottis. Following this procedure, she was unable to eat or drink and for almost 6 months she had to be fed liquid food through a tube that was inserted up her nose and down into her stomach. She did not leave the house except to attend medical appointments. She remembers a hot summer and feeling thirsty but being unable to drink anything because all hydration had to go through the nasogastric tube. Her son Dayne gave up work to look after her because she could not manage on her own. He had to be trained to manage the feeding equipment and it was given four times a day. The only respite for him was when her sister came to stay or a trusted friend came round to sit with her for a few hours. He had to be back each time the feed or medication was due and for hydration throughout. She said that the whole experience was very emotional and she felt very frustrated, anxious, depressed and did not hold much hope for the future.
25. During this time, there were discussions with her consultant about having a full laryngectomy. The prospect of the procedure was very daunting and the decision caused her a great deal of anxiety and stress and her son Dayne was a huge support to her at this time. She decided to undergo the procedure.
26. In her witness statement dated 18 May 2023, the Claimant described how she underwent a total laryngectomy on 17 July 2017. It was a long operation and post operatively there were complications requiring her to undergo a further operation on 25th of July 2017. Following each operation she was nursed in ITU before being moved to a ward. She was in hospital for approximately five weeks. Post-operatively, she could not breathe through her mouth or nose but instead had to breathe through a hole in her

neck. She found this very strange and frightening and it took her a long time to adjust. She could not speak, which she found frustrating. During this time, her care needs were being met by hospital staff and her family and close friends were visiting and their emotional support was very important to her. During this period, her son Dayne attended training sessions to learn about stoma and airway management.

27. When she was discharged from hospital, she still had the feeding tube in place and could not eat or drink by mouth, nor could she speak. She relied upon her son 100% of the time. She was unable to manage her airway and stoma herself and therefore relied on him to suction and clean her airway when it was needed. It became blocked a lot and this could happen at any time of the day or night. She said that, as at May 2023, that remained the case.
28. In the aftermath of being discharged home, the feeding regime, via the nasogastric tube, continued 4 times a day and this carried on for months post-operatively. She was eventually able to wean herself off the nasogastric tube, starting with liquids, then soft foods by mouth and gradually progressing to normal food, although she found that she still needed to cut her food into small pieces. I observe that her dentition was very poor at this time, it having been poor pre-radiotherapy and having been made very much worse by the radiotherapy.
29. She described being pleased to be at home for her birthday on 9 September 2017, but then feeling completely devastated and overwhelmed by the sudden realisation that she could not blow out the candles on her cake. She described being unable to do things around the house like cleaning or lifting anything, and feeling useless. She said that her son ended up doing everything and he had to be around 24-hours a day. They had a bell that she would use if he was in a different room when she needed him. He had to help her with personal care, with washing and in particular with washing her hair as she was very frightened about getting water in her airway. During this time, she was unable to communicate verbally which affected many aspects of her life and her son had to take these on for her.
30. Dayne Cullen gave a witness statement dated 11 May 2023 in which he described undergoing training before his mother could be discharged from hospital following her laryngectomy. He had to learn how to manage her airway and the stoma and to keep them clean. Although his mother tried to do this, she was physically unable to do it on her own. He said that that remains the case. He described the procedure as very delicate and needing good eyesight, a steady hand, precision and confidence. He was very anxious doing it at first because he was frightened that he would hurt her. The procedure had to be done routinely, and as needed, because the airway gets blocked very easily which means she cannot breathe. It had to be done at least 5-6 times during the day, and sometimes during the night too. She also had to use a nebuliser machine at least 3 times a day and as needed. If her secretions were hard, it was used more frequently. He described the daily routine as involving suctioning and cleaning the stoma at the start of the day and being available at any time (day and night) to clear the stoma and clean it. He described how, whenever they went out, they had to prepare a bag of equipment to take with them to clear and clean the stoma.
31. On 16 January 2018 and 7 March 2018 there were assessments of the Claimant to which Joan Flock (social worker) and Sylvia Lindsay (senior practitioner) contributed. These were broad assessments, concerned with many aspects of the Claimant's condition that

are not relevant to the issues that I have to determine. However there were aspects of each assessment that are of particular relevance. On 16 January 2018, the Claimant was recorded as having said “I have an internal voice valve, which gets blocked and leaks, when this happens I am unable to speak or communicate with anyone, resulting in others having to anticipate my needs. It needs to be cleared using a technical procedure, which my son has been trained to do. The speech and language team are involved and I attend regular appointments at the Royal London and UCLH.” In relation to breathing, she was recorded as saying “I need to have a suction machine with me at all times, I also have other equipment such as a neck mask and inhaler, which keep my airways clear and enable me to breathe.” Under the heading medication, “Although it is not medication as such, without the procedures currently undertaken by my son to keep me breather (sic) and airways clear are done in a timely manner, it would be detrimental to my health and well-being, as there are some procedures, which need to be done 4-5 times a day and are unpredictable in their nature.” In the outcome section, the assessors state that “her son has given up work to support his mother and is currently undertaking all her healthcare needs and procedures needed to keep her airways clear.”

32. On 7 March 2018 the Claimant’s situation was recorded in similar terms to the January assessment. At this time, the procedures need to keep the Claimant’s airway clear were being undertaken 6-8 times a day and remained unpredictable in nature. It was also recorded that a couple of friends were assisting Dayne and the assessor was present when one of those friends visited for this purpose. It also recorded that Dayne was finding it more challenging to support his mother “day and night”. During the assessment, the assessor observed the Claimant’s voice valve becoming blocked and her son having to unblock it.
33. In March 2018 the Claimant began to receive funding for 40 hours of paid care per week, paid for by her local authority, the London Borough of Islington. Her case is that she continued to need 24 hour care and assistance, but this funding enabled her to start to engage friends on a paid basis to provide some of her care, easing the pressure on her family and particularly on her son Dayne.
34. During 2018 it became apparent to Joan Flock that the Claimant required assessment by Continuing Healthcare (CHC) with a view to the provision of her care transferring from the local authority to the NHS. That assessment process took place during the summer of 2018 and is well-evidenced in the documentary records.
35. As part of the CHC assessment process, a report dated 25 July 2018 was prepared by Nicola Gilbody, a highly specialist SLT at the Royal London Hospital. This report is an important document and provides a very helpful early snapshot of the Claimant’s condition and for that reason, I reproduce it in full. Its value is enhanced by the fact that it comes from a SLT (the specialty to which all the other experts in the case have deferred when it comes to the management of the Claimant’s stoma and voice valve/prosthesis) who was involved in the Claimant’s care and whose involvement predated any litigation (the letter of claim was not served until well over a year later).

I am writing to inform you of our involvement with the above lady who underwent total laryngectomy, bilateral neck dissection, and pectoralis major flap reconstruction in July 2017, following previous treatment with chemo/radiotherapy for T3N0M0 SCC larynx.

Laryngectomy involves the surgical removal of the larynx (voice box). The trachea (airway) and pharynx (food pipe) are completely separated and the trachea is diverted through a permanent opening in the neck, called the stoma. There is no longer a route for air via the mouth or nose, and the person becomes a neck breather.

Mrs Cullen requires daily care to her voice prosthesis and her stoma in order to maintain her airway, minimise risk of infection or respiratory difficulties and maximise her ability to communicate. This care is essential in order to maintain a safe and healthy airway and will be required on an ongoing basis for the remainder of Mrs Cullen's life.

Due to difficulties with dexterity and vision, Mrs Cullen is unable to self-care and therefore needs assistance from a trained care-giver on a daily basis. Further details on this care are provided below.

Respiratory function

As the stoma is the permanent route for breathing in the neck, air no longer passes through the body's natural humidifiers-the nose and mouth-during inhalation and exhalation. Instead air enters and leaves the lungs directly through the stoma. Without the body's natural humidifiers, the air that enters the lungs is often dry, cold and dirty.

To maintain a healthy respiratory system, Mrs Cullen needs to use specially designed filtering and humidification systems to stop the fumes, dust, pollen etc from entering the airway. Nebulisers and suction equipment are also required on a daily basis to loosen dried secretions and prevent mucus plugs which could result in respiratory failure.

Mrs Cullen is at an increased risk of infection, particularly chest infections, due to her status as a neck breather and an underlying diagnosis of COPD (chronic obstructive pulmonary disease). Patients can deteriorate relatively quickly with any difficulty relating to the chest affecting their breathing. For this reason, she requires swift access to suction machines and nebulisers to clear excessive mucus which would otherwise impair her respiratory function.

Stoma care

As part of her daily routine, Mrs Cullen must thoroughly clean the skin around the stoma and remove any secretions from within the stoma itself. This can involve use of gauze, swabs and tweezers which requires a level of dexterity which Mrs Cullen struggles to achieve independently and she therefore requires the assistance of a trained carer to carry this task out. If stoma care is not performed appropriately, Mrs Cullen is at risk of the stoma becoming blocked, or plugging off, which could result in respiratory failure.

Voice prosthesis

With the removal of the vocal cords (also known as vocal folds) and the diversion of the air through the stoma instead of the mouth and nose, normal voice production is no longer possible. Mrs Cullen has undergone a procedure to provide surgical voice restoration, where a voice prosthesis is inserted into a puncture between the trachea and the oesophagus. Patients with this speech method have to clean and maintain the voice prosthesis to avoid infection risk and the risk of the prosthesis becoming dislodged or blocked.

Mrs Cullen requires a clean, safe environment and assistance to use small cleaning brushes/pipettes to care for the voice prosthesis adequately. Failure to care for the voice prosthesis properly could lead to infection which could obstruct her breathing.

Current care provision

Mrs Cullen's son is her designated trained carer. She relies on him to perform these stoma and voice prosthesis management tasks several times a day. As explained above, without his assistance she is at risk of developing infections which could lead to respiratory difficulty. Mrs Cullen would benefit if all of her carers were trained to support her in these tasks.

36. The assessment and recommendations contained within Nicola Gilbody's letter were subsequently endorsed on 6 August 2018 by a multidisciplinary team of assessors deciding upon an application for funding from NHS Continuing Healthcare. Their assessment is contained within a document entitled 'Decision Support Tool for NHS Continuing Healthcare'. The team of assessors comprised five healthcare professionals: Nicola Gilbody, Pablo Lopez-Quiros (the Claimant's district nurse team manager), Dr Marie-Claire Hancock (the Claimant's general practitioner), Joan Flock (the Claimant's social worker) and Richard Dampney (described in this document as a specialist continuing care nurse, and elsewhere as a CHC nurse assessor). The summary drawn from the multidisciplinary assessment includes the following:
- "She requires on-going support with respiratory care. Particularly with laryngectomy stoma care. She needs suctioning of respiratory secretions by a skilled caregiver 8-12 times/day in order to minimise high risk of chest infection, pneumonia and hospital admissions. This is not a predictive task; hence Ms Cullen may require hourly suctioning of respiratory secretions."
37. The result of that assessment process was that from 11 September 2018 onwards, the NHS took over the funding of the Claimant's paid care, with a CHC Care Plan providing for a total of 104 hours paid care per week. This was subject to annual review. The terminology used to refer to this NHS-funded care varied during the trial. The most common shorthand employed by counsel and the Claimant herself was to refer to both the funding and the funder as 'CHC', which is the shorthand that I shall use in this judgment.
38. With the increase in the number of hours of paid care in September 2018, the Claimant began to employ more carers. Her evidence was that her care was personal and she preferred to have it provided by people she knew well. She recruited her carers from amongst her friends and individuals introduced to her through her friends. It also became possible for her to pay her sons for at least some of the care they provided, although whilst the number of hours per week remained at 104, her family and friends continued to make up the difference between that and full-time care. The Claimant makes no claim against the Defendant in respect of the funded care. Her claim for past care is limited to the additional gratuitous care provided by her family and friends.
39. The funding arrangement with CHC was that CHC set a budget and she was responsible for meeting her care needs from that budget. Each month CHC would place funds into an online account/portal and the Claimant would make payments from that

account/portal directly to her carers. Allegations (ii) and (iii) of fundamental dishonesty relate to her management of her budget and payments to carers during lockdown in 2020 and at times when she was away on holiday. I shall address those allegations later in this judgment.

40. On 18 August 2021, Professor Homer (Claimant's ENT expert) interviewed and examined the Claimant and later provided a report dated July 2023. He endorsed the letter of Nicola Gilbody dated 25 July 2018 and the Decision Support Tool document dated 6 August 2018 (see above) as a reasonable summary of the effects on the Claimant of her laryngectomy and that much of it continued to apply at the time of his assessment. He described frequent difficulties with her speech valve requiring frequent valve changes and he cross-referenced to the clinical records which supported this observation. He recorded that she required help cleaning the valve as she was unable to do it due to limitations with her dexterity and eyesight. He recorded that she required assistance caring for and managing her stoma (cleaning, cleaning and inserting tubes/stoma base plates etc) due to limitations with the dexterity of her hands, particularly on the right-hand side, as well as poor vision. He recorded that a suction machine and the use of a nebuliser were required, as was filtration and humidification via an HME device. He recorded that she felt that her breathing/shortness of breath had been gradually deteriorating. In the opinion section of his report, he opined that "the need for care that she currently receives will continue for life". He stated that she had a consequent need for care and assistance 24 hours per day.
41. In September 2021 a CHC review recorded that this situation continued, with the need for suctioning varying but it was usually required at least once every hour. It also recorded 3 chest infections in the previous 6 months. It was in September 2021 that her CHC funded care was increased to 168 hours per week.
42. On 22 July 2022, Anna Crowley, one of the Claimant's carers, provided a witness statement in which she said that the most important task that she and other carers undertook was helping the Claimant to maintain her airway, which she could not manage on her own. Some cleaning tasks and nebulising were carried out routinely at intervals during the day but a problem could and frequently did arise. She said that large secretions often got stuck in the Claimant's airway, affecting her breathing, and they had to be manually removed by a carer. This could happen at any time, day or night, and when it happened, it was urgent and potentially life-threatening and a carer had to be on hand with the correct equipment. She described a carer being on hand overnight and described the Claimant waking two or three times during the night and using a bell to summon assistance. Cleaning the Claimant's stoma involved the use of the suction machine and the use of surgical, angled forceps to remove any built-up mucus and secretions. She described cleaning inside the stoma as a very delicate procedure requiring confidence, a steady hand, good eyesight and a reliable torch, as care had to be taken not to dislodge the voice prosthesis. She said that she and Dayne trained other carers and although it could be daunting at first, with practice they got the hang of it. So far as the voice valve was concerned, she said that she was not trained to deal with it and so if something went wrong, an urgent hospital appointment was required. If it became dislodged, they had to retrieve the valve and make sure that the Claimant's puncture is kept open, either by inserting a plug or a 'gastro tube'. They would then contact the SLT team for an emergency appointment but if one was not available, or not for several days, the Claimant would be unable to speak and would have to keep the

plug/tube in place until the SLTs could replace the valve. She personally had been present for most of the Claimant's many valve changes and was keen to learn how to do things well and improve her skills.

43. In August 2022 a review recorded that she made regular use of a nebuliser to loosen secretions, that she had a good cough and was able to bring up her secretions but was not strong enough to expectorate them, which required frequent suctioning and also required a carer to remove thick secretions using a clamp (which I take to mean forceps). She reported shortness of breath when climbing stairs. She reported attending the Royal London Hospital every four to five weeks to have her speaking valve changed.
44. On 23 August 2022, Mrs Howison (Claimant's care expert) attended the Claimant's home for the purposes of assessing her care needs. Dayne Cullen and Annie Courtney (carer) were present at the time of her visit. During the course of the visit, Dayne Cullen and the Claimant described the Claimant's stoma care to Mrs Howison and she recorded it in her report (it appears in the section dealing with August 2017 to March 2018, but she later states that these care needs continued as at the time of the report). She also took photographs, which are included within her report, showing "Dayne performing airway care, using a light source to identify debris which is then removed with forceps or suction. I understand that debris can get trapped on the speech valve (shown in the last photo), this can be cleaned in-situ with a small brush." Mrs Howison records how the Claimant experiences issues with clearing thick and dry secretions from her airway. She states that the secretions build up and dry out overnight and using an airway tube overnight makes them easier to manage. "During the day and overnight Wilma may need airway management a few times an hour or once every 2-3 hours, this is not predictable. Airway management involves using a suction catheter to remove secretions and forceps if there is a piece of mucus/debris stuck. Her speaking valve needs cleaning with a small brush and position adjusting as required, if this leaks then fluid bypasses into her airway. On occasions urgent re-siting/replacement of the speech valve is necessary, sometimes this happens monthly, which involves liaising with the SLT team and attending an emergency appointment. Normal planned valve changes occur every three months." She records Dayne describing "ad-hoc unpredictable airway management required day and night." So far as the Claimant's voice valve was concerned, Mrs Howison recorded that it dislodged on occasions and the hole at the back of the stoma had to be plugged until the SLT team can arrange to replace the valve. On occasions this has taken up to 3 days, during which the Claimant could not speak. Reinsertion of the valve was a clinical process that the SLT team fulfilled. Mrs Howison recorded that during her assessment, "[she] witnessed [the Claimant] need unpredictable stoma and airway management with use of suction and forceps 4 times in 2.5 hours."
45. On 10 October 2022, Marie Palmer (Defendant's care expert) assessed the Claimant at her home. Anna Crowley was present throughout. Miss Palmer recorded that the Claimant "requires the use of equipment to care for the stoma, to provide humidification and filtration of air entering her lungs. Ms Cullen said that she requires constant suctioning of secretions. She reported that she occasionally sleeps 4-5 hours and that secretions build up during that time as she is lying down. She stated that the secretions can be hard in the morning and that the carer might need to suction the secretions two or three times but that at other times, it could be more or less. Ms Cullen advised that

she uses a nebuliser at least twice a day to make the secretions easier to cough up or to suction. She stated that she might use it more frequently if she has a chest infection, for example. She has two portable suction machines, one of which she takes with her when she goes out. Ms Cullen said that she experiences two or three ‘bad’ episodes per day where the carers need to use ‘scissors’ to get the phlegm out. Ms Cullen reported that she is dependent upon her carers to care for her stoma as her vision is poor and she does not, therefore, trust herself looking in the mirror to suction secretions and saliva. She advised that she also has a little tremor in her hand, although this was not evident at the time of my assessment and I have not seen evidence of this in the medical records or other reports.” Ms Palmer recorded that Ms Cullen “told me that whereas she was previously very independent, she is now reliant upon her family and friends to provide 24-hour care as she cannot be left on her own.” Ms Palmer recorded that the Claimant had had a voice prosthesis fitted, that she continued to be under the care of the St Bartholomew’s SLT team, and that her care would be provided by this team for the rest of her life. She recorded that as a result of the valve leaking, the Claimant experiences chest infections which last for 3 to 4 weeks. I note that Ms Palmer also recorded that during the assessment, Anna Crowley used the yankauer on one occasion to clear secretions and the forceps on two occasions.

46. On 20 October 2022 and 10 November 2022, the Claimant was assessed in her home by Ruth Ainley (Claimant’s respiratory physiotherapy expert). Anna Crowley was present throughout on both occasions. In her report, Ms Ainley recorded that “on both visits, Mrs Cullen coughed several times in the hour I was with her: her carer used the yanker twice, and the forceps once to remove a piece of dried mucus”. In February 2024, when the self-changer issue arose, Ms Ainley provided a short supplementary letter dated 23 February 2024 in which she said that “having witnessed the carer Anna Crowley removing a small plug of mucous with a torch and tweezers in daylight, I can see how challenging being independent with tracheotomy management remains for Wilma.”
47. On 31 January 2023, Holly Spencer (Defendant’s respiratory physiotherapy expert) assessed the Claimant at her home. Anna Crowley was present throughout. Ms Spencer recorded that during the time she was with the Claimant, she required suctioning approximately five times per hour. Mr Spencer recorded that “the secretions observed were thick and creamy in colour with no blood staining.” Of particular note, Mr Spencer “observed on one occasion that the secretions were becoming difficult for Ms Cullen to clear with her cough and she became anxious and signalled for suction from Ms Crowley urgently. A small amount of tenacious brown secretions were cleared using suction which Ms Cullen had been unable to clear out of her tracheostoma independently.”
48. I pause there to observe that Mrs Howison, Ms Palmer and both respiratory physiotherapists, Ms Ainley and Ms Spencer, all observed the Claimant getting into difficulty and requiring assistance from Anna Crowley or Dayne Cullen to clear her airway. It is a feature of the evidence that many experts (and other assessors) have witnessed similar care being provided. It is notable, in a case where the honesty of the Claimant is under attack, and the need for care is challenged, that none of the experts/assessors have expressed any concerns as to the authenticity of what they have witnessed. On the contrary, Ms Ainley’s letter of 23 February 2024 expressly confirms the challenges the Claimant faces.

49. On 20 February 2023, Samantha Holmes (Claimant's SLT expert) assessed the Claimant at her home. Anna Crowley, was present throughout and Annie Courtney was present for the second half of the assessment. Miss Holmes recorded the small size of the Claimant's stoma. She recorded that the Claimant reported a high secretion load, meaning that she needed to clear a large amount of phlegm from her chest via her stoma. She stated that the Claimant could "independently perform some of the care tasks related to caring for her stoma, but does require assistance from her carers for the majority of tasks due to limited dexterity and ability to visualise the stoma/voice prosthesis." Furthermore, "the voice prosthesis requires frequent cleaning to remove debris from within the valve and to keep the flapper functioning. This is done by inserting a small brush into the barrel of the valve. Ms Cullen requires assistance with this from her carers as she is unable to see the valve in order to insert the brush into the barrel." In relation to the voice valve, Ms Holmes recorded that "in Ms Cullen's case, valve changes are performed by her carer, Ms Crowley, and the St Bartholomew's SLT team." I observe that this description of valve changes being performed by Anna Crowley is consistent with the contemporaneous SLT records, as clarified.
50. On 13 March 2023, Kate Heathcote (Defendant's ENT expert) interviewed the Claimant over Zoom. Her report dated September 2023 contains a very brief record of what she was told by the Claimant in the course of their Zoom call. The Claimant informed Ms Heathcote that she had a carer present 24 hours a day, seven days a week so as to help clear secretions that may block her stoma and also to assist with household chores. The Claimant also informed Ms Heathcote that she wore glasses for long-sightedness and said that her vision made her stoma care difficult. Ms Heathcote recorded that one of the Claimant's carers was present during the consultation and on a couple of occasions, the carer intervened to help with suction. Ms Heathcote expressed no reservations about this. She also recorded that the Claimant had her voice valve changed every 4-6 weeks at the hospital, although her carers were being trained to do this at home. Again this is consistent with the contemporaneous SLT notes as clarified.
51. On 18 May 2023, the Claimant provided a lengthy witness statement detailing various aspects of her claim.
52. So far as her stoma was concerned, she said:-
 - i) "We use a nebuliser several times a day to moisten my airway and to loosen secretions to make it easier to clear them. If I get any increase in secretions for whatever reason, it gets so bad that I cannot breathe and it is very frightening. I get regular chest infections and I have to take antibiotics but it takes me a long time to get well again.
 - ii) The tube gets blocked very regularly and has to be suctioned and cleaned out or I cannot breathe. It varies depending on weather and environmental conditions, but I estimate that the tube has to be cleaned an average of 5-6 times during the day but a blockage can happen at any time of the day or night. It is essential that it is cleaned carefully because of the risk of infection. It is noisy and can be messy. It is not a pretty sight, watching someone's tube being cleaned out. I am very conscious of it and other people's reactions...
 - iii) My sleep is interrupted because my stoma often needs cleaning late at night during the night or early in the morning."

53. So far as her voice prosthesis was concerned, she said:-
- i) “It has taken a long time to learn how to use the voice valve effectively. People struggled to understand me. The sounds were garbled initially and trying to make others understand me was very frustrating indeed.
 - ii) I’ve attended the hospital frequently to undergo a valve change. From what I have been told, I have had more valve changes than most due to the spasms I have, this situation is ongoing.
 - iii) Although the voice valve is fixed in place in the puncture (hole) inside the stoma, it can easily become dislodged at any time for example by a body movement or coughing. When this happens, it is important to recover the voice valve and prevent it going into my lungs. If this happened, I would have to have it removed surgically. (I accept that the Claimant believed this to be the case, but I also accept the evidence of Ms Heathcote that this would not in fact require surgery but it would, nevertheless, require a procedure carried out in theatre.)
 - iv) When the valve becomes dislodged, we must ensure the puncture hole is kept open by inserting a tube (similar to a gastric tube) into the puncture hole straight away and seek medical attention. It is vitally important that the puncture hole remains open and does not close, because if it closed it would cause major problems and I would need surgery to reopen it.
 - v) When the voice valve becomes dislodged, a new valve has to be fitted promptly and correctly, but this isn’t an easy process. In the past when it happened at the weekend or when the SLT team are not on duty (they run day clinics on Monday to Friday only), I have had to be intubated and remain like this until a qualified clinician could attend to it. Until a valve is refitted, I am unable to communicate verbally so must rely on others to speak on my behalf.
 - vi) My main carer, Anna, has observed the process of replacing the voice valve many times and has been successful at doing it at home but we both know that proper training is needed so that carers can do it competently and with confidence. The hospital SLT staff are sceptical about us being able to do this procedure safely; they emphasise that there is a high risk of infection. (I observe that this is consistent with what we now know to be the true meaning of ‘self-changer’ and with the contemporaneous SLT notes.)
 - vii) Using the voice valve, I can now usually communicate one-to-one for a reasonable time before there is a blockage. When it becomes blocked, I cannot speak until it is cleared.
 - viii) It worries me that I am so dependent upon others. The stark fact is that without help, I cannot manage my airway and breathe.”
54. On 24 May 2023, Mark Williams (Defendant’s SLT expert) assessed the Claimant at her home. Anna Crowley was present throughout. He recorded that Ms Cullen “is able to manage some of the features of self-care in relation to her stoma but reports the need for assistance for the majority of these because of reported difficulties with dexterity and her ability to visualise her stoma and voice prosthesis/valve. Her valve is changed

every three months by her carer, and by the SLT team at St Bartholomew's Hospital. Her carers have received informal training in relation to the management of Ms Cullen's prosthesis so that much of the above intervention may be conducted at home." Again this is consistent with the SLT notes as clarified.

55. Although in this section of my judgment I am considering factual evidence, I interpose the assessments of the clinical psychologists into the chronology because they were conducted at a time when the Claimant was not on notice of any allegations of dishonesty and one of them specifically tested for malingering/exaggeration. In March 2023 the Claimant was assessed by Dr McGillion, clinical psychologist instructed by the Defendant. She did not specifically test for malingering, but concluded that the Claimant "appeared to be a sincere and reliable informant. There was no evidence of conscious exaggeration." In June 2023, the Claimant was assessed by Dr Carstairs, clinical psychologist instructed by her own solicitors, who did test for malingering/exaggeration, administering tests MMPI-2 and TSI-2. She found "absolutely no indication of any exaggeration" of her psychological symptoms. I accept that these reports addressed psychological rather than physical symptoms, but I consider the absence of exaggeration in this part of her claim to be supportive of her honesty/reliability in other parts of her claim.
56. In September 2023 a CHC review recorded that she continued to use the nebuliser regularly to loosen her secretions, that she had been producing a lot more secretions lately and her stoma site had been sore and had reduced in size, requiring her to use the smallest size tube to maintain the opening. During the assessment the assessor observed the Claimant coughing up secretions which then had to be removed by Anna Crowley using the 'yankauer' suction device

Surveillance evidence

57. In early January 2024, the Defendant undertook surveillance outside the Claimant's home. I record it here in the chronology, but I shall consider it when I consider the evidence given at trial.

Up-dated medical records

58. In January 2024, up-dated medical records were obtained. The speech and language therapy records, from about September 2022 onwards, included references to the patient self-changing her voice prosthesis at home. These records were relied upon by the Defendant and were summarised in the Defendant's Amended Counter-Schedule as follows:-
- i) On 21 September 2022, the Claimant had "changed VP herself yesterday (against SLT advice)" and "reported that the change went well" and "felt confident in changing VP and that it was in properly", and she had been "eating and drinking since with nil concerns".
 - ii) On 13 December 2022, the Claimant "attended for review on VP, has been self changing VP at home", and the Claimant then in the clinic "self changed VP independently", demonstrating sufficient competency that the speech therapist thereafter had "Nil concerns with [the Claimant's] ability to self change VP".

- iii) On 28 March 2023, the Claimant was documented to be a “competent self changer”.
 - iv) On 23 October 2023, the therapists noted that they themselves “Do not have complete valve change history from Dec 2022 onwards as [the Claimant] then started self changing”.
59. In addition to the records relied upon by the Defendant, the updated records contained a number of other entries. The following are of particular relevance to the issues in the case.
- i) On Friday 22 July 2022 the Claimant attended with her son Dayne at the outpatients’ clinic at the Royal London due to her voice valve having been leaking on and off whilst on holiday in Jamaica. The leak was observed on examination and a valve change was indicated. There were 2 SLTs present, but between them they could not change the valve. The notes record that “Wilma’s valve changes are known to be very complex, even at senior SLT level. Further support needed from SLTs more experienced in this remit in order to complete change. This was explained to Wilma who was frustrated about not being able to have a valve change today.” The notes record safety measures pending a valve change the following week. Those measures were the use of thickener (something the Claimant particularly dislikes), the placement of a plug and admission for hydration. In relation to the placement of a plug, the notes record: “Plug: tricky placement of plug due to small stoma, deep puncture and angled party wall that makes placement of plug tricky. SLT attempt x4 but not successful.” In my view this entry provides powerful support for the evidence of the Claimant and her carers about the difficulties that they face in managing her voice prosthesis.
 - ii) The notes also record that the Claimant had contacted the department on 20 September 2022, the day before the first of the entries relied upon by the Defendant, and had informed the SLTs that the change had been carried out with the assistance of her carer. It is not clear why this important detail was not recorded in the notes on 21 September 2022.

Effect of up-dated medical records

60. The timing of the arrival of the up-dated medical records meant that some, but not all, of the joint statements were produced with sight of those up-dated records. The references to self-changer had a profound impact on the litigation. As later became clear, the Claimant was in fact not a self-changer, but that was not yet known when the joint statements were prepared.
61. The SLT experts, to whom other disciplines deferred when it came to stoma and voice valve management, did have the updated records. They agreed that voice prosthesis care is more complex than care of the stoma and if the Claimant was a self-changer for her voice prosthesis, which they took to mean someone who is able to independently change their own voice prosthesis, then it follows that she must be able to perform care tasks such as cleaning and suctioning. As a result, they agreed that she did not require 24-hour care in future and instead supported the proposition that had been advanced by Marie Palmer in her report, namely that there would be a period of weaning the

Claimant off her existing care and thereafter she would require no more than a modest amount of support worker input, supplemented with more intensive assistance during periods of illness.

62. When the care experts met to discuss their joint statement, they had the updated medical records and the joint statements from other experts. They agreed that the medical records demonstrated a progression of skills that neither expert was previously aware of and that if she could now complete the valve changes, then it is reasonable for her to complete the other aspects of tracheostomy care with minimal/no carer support. They considered that the provision of funded care had led the Claimant to become disempowered and resigned to living with disability and reliance on others. They specifically agreed that they were not suggesting that the evolution of this reliance on others was deceitful. They did not support 24-hour care into the future. They both now supported Ms Palmer's recommendation that there be a period of rehabilitation to address the Claimant's (perceived) dependence on care and thereafter some planned assistance would be reasonable to complete personal care, together with additional care during periods of illness.
63. The Defendant then applied, by application notice dated 8 February 2024, to amend her counter schedule to plead fundamental dishonesty.
64. The Claimant applied, by application notice dated 19 February 2024, to amend her Schedule of Loss to bring it into line with the revised expert opinion, in particular, the revised opinion of Helen Howison in relation to the Claimant's care needs.
65. Those applications came before Mr Justice Soole on 20 February 2024 and were granted. There was permission to the parties to serve further evidence by 23 February 2024. It was ordered that the trial would start on Friday, 1 March 2024, the Defendant having specifically asserted that her amendment would not extend the time estimate of six days.

Clarification of the medical records by members of the SLT team at the Royal London Hospital

66. On 8 February 2024, the Claimant contacted Freya Sparks, one of the SLT team, by email as follows: "I have been informed that according to my records I am now described as "self changing", which is fine however I am being assessed for other reasons and the term "self changing" is a very loose term and it somehow indicates that I change my valve without any help at all. As you are aware I rely quite heavily on my carers to help meet carry out successful valve changes. To be honest I am not sure I would be able to fully perform the change without their help (normally Anna). This is due to the difficulty I normally have is the position of my puncture is awkward, and sometimes I find it quite impossible to see, therefore I rely on help. Also I find it hard to insert gel caps without help. Think it would be a bit daunting to do this entirely on my own. Would it be possible to include in my records that although I am "self changing" I actually rely on carers to assist and help with the valve change. Every time we change valve I sent a message explaining that myself and my carer have changed the valve together. I would just like this position to be clear in my records as it can cause problems for me if interpreted that I am totally independent."

67. On 21 February 2024, Freya Sparks made the following entry in the medical records: “Pt contacted SLT team to request that entry is placed in her medical notes regarding status as voice prosthesis self-changer. Wilma is able to self-change prosthesis following previous training with the SLT team. However in order to do this safely and effectively, it requires a carer to be present to support the change. The role of the carer within the change is to enable Wilma to self-change by assisting with tasks such as positioning of mirrors, providing a light source, visual confirmation of prosthesis placement in tract, visual confirmation of no-leak, and removal of the prosthesis tab. We consider it necessary for Wilma to complete her self-changes with a carer present to ensure it is safe and effective, and to avoid the need to attend the hospital for SLT led changes.”
68. Although it is obvious that this entry was prompted by the Claimant’s email, it is much less clear where the contents of the entry came from. They do not entirely accord with the email from the Claimant and since the valve changes had been taking place at home rather than in the hospital, it seems very unlikely that it was based on Freya Sparks’ own observation of it being done (it appears that the Claimant and Anna Crowley did change the voice prosthesis in clinic on 12 December 2022, but Freya Sparks was not the SLT who was present on that occasion).
69. On 23 February 2024, Lindsay Lovell, who is the clinical lead SLT at the Royal London Hospital, made a witness statement. She states as follows: “I am one of Wilma’s treating SLTs and have been treating her since 2022. The SLT team at the Royal London Hospital have been treating Wilma since her laryngectomy surgery in 2017. I have been asked to explain the terminology “self-changing”. Self-changing is a term that can be used to represent a range of independence in how someone manages their voice prosthesis/valve. In Wilma’s case, “self-changing” means that she no longer needs her treating SLT team to complete her changes at hospital and she can now do her changes safely at home. It is a difficult procedure, and she needs the support of one of her carers, for instance Anna Crowley, to assist with the changes. Whilst she is safe to do a valve change at home, the change requires a trained carer present to support and ensure that the change is safe and effective. This is due to the various steps involved and the difficult position of Wilma’s puncture in her tracheal wall, which Wilma, her carers and her treating SLT team all find a little tricky. I understand that the terminology “self-changing” in Wilma’s SLT records can be misunderstood. The records have now been updated and the SLT team are aware that going forwards, that they will document this clearly in Wilma’s records.”

Further witness evidence

70. On 23 February 2024 the Claimant provided a further witness statement responding to the allegations of fundamental dishonesty and in particular the allegation that she was a “self-changer”. She said that she did not change and manage her voice valve herself and that she required help from either one of the SLTs or one of her carers to do so. She said that although she can do some of the different aspects of the valve change, she could not imagine doing it by herself. This was partly because of the position of the puncture into which the valve is inserted. She said the position was awkward, situated very low and was very difficult to see and get to. She had to tilt her head back for the puncture to be appropriately visible and in that position, she could not see it herself. She commented that she had slightly poor vision, but even with perfect sight it would be difficult to see. She said that she cannot put the valve into the puncture by sight or

feel and therefore it has to be inserted by someone else. She said that she did not attempt to change her valve on her own without a carer or SLT and would not feel confident doing so. She commented that the entry that Freya Sparks had put in the notes, saying that it confirmed that she needed to have a carer present. She said that in reality, she and her carer do it together and do different things each day. Freya Sparks' description was one of the many possible divisions of labour. It was faster and easier for the carer to do most of the change, but precisely who did what did not affect the need for the carer to be present throughout. Sometimes the change was straightforward, sometimes it was not. She described being very nervous and frightened by changing valves. She described needing help removing secretions from her airway frequently and unpredictably. She described a recent occasion when she and Anna Crowley had been shopping and a large solid piece of phlegm had got stuck, she could not clear it herself and was finding it hard to breathe and Anna Crowley had had to remove it with forceps in the middle of a supermarket aisle. She also described how there had been occasions when she had attempted to clear her own airway and had accidentally dislodged her valve due to not being able to see adequately into her stoma. When the valve is dislodged, her carer has to insert a gastric tube into the puncture and she cannot speak until the valve is replaced. She explained why her claim had been amended following receipt of the updated medical records. She said: "when the joint statements of the meetings of experts were served I was advised that the value of the case had changed and that I could no longer claim 24-hour care. I accepted the change in the experts' views even though they were based on the misunderstanding of the term in the records of 'self-changing'. I don't think this is fair now."

71. On 23 February 2024, Anna Crowley provided a further witness statement in which she said that "Wilma is just not able to change her own valve. She has never done it without someone being there to help. It is really tricky to do and has taken me a while to get better at it and even then sometimes I find it more difficult than at other times. No two valve changes are the same." She then went on to explain how she was shown how to do the changes by the SLTs and how she and the Claimant now did the valve changes together. She described what was involved and what the Claimant could do. She described how Wilma could use forceps to grab hold of the tag that is attached to the valve but which sits outside the stoma (this was confirmed by the visual examination of the Claimant's stoma and the valve that was in situ on 5 March 2024). In order for the Claimant to be able to do this, Anna Crowley had to hold the mirror and torch in the right position. She described how the Claimant was able to put in the lary tube that is used to stretch the stoma. The next task is to fit a gel cap onto the new valve, which she said the Claimant found incredibly difficult and most of the time could not manage it. Anna Crowley said she also found it a fiddly task and it can take her many goes to do it, although sometimes she got it in first time. She said it was a bit like threading a needle. She said that in order to put the new valve in, the Claimant has to put her head back and she, Anna Crowley, inserted the new valve. It was much easier for her to do it than for the Claimant and so she did it. Then, once the new valve was in place, Anna Crowley had to look and check that it had gone in right, which was something that the Claimant could not do. She said they changed the valve every 2 to 3 weeks, or if it got dislodged.
72. She described how she and Dayne were the ones who changed the valve, although other carers were learning. If the Claimant was going away on a trip, she would change it just before she goes. If there is a leak whilst the Claimant was away, the carer who was with

her would try and clean the valve with brushes and if that was unsuccessful, the Claimant would have to drink thickened drinks to stop the leak. If a valve was dislodged when Anna Crowley was not present, the carer who was present would need to insert a gastric tube. She estimated that that probably only happened two or three times a year.

73. Anna Crowley also said that the Claimant needed her stoma clearing very often throughout the day. The Claimant would try and clear it herself by coughing it out or by using the suction machine. However she found it more difficult to use the forceps to pick out harder bits or bits that are stuck further down. Anna Crowley estimated that she had to step in to help the Claimant about 50% of the time if they were at home and more than that if they are out in order to speed up the process.
74. On 23 February 2024 Dayne Cullen provided a further witness statement in which he stated that his mother was not a “self-changer” and could not change the valve on her own. He said that she had never done it and she relied on one of her carers to help her with the change or to clear the stoma when it got blocked. He said that they went to hospital much less than they used to for the valve to be changed. He said that his mother’s valve was in a very awkward position and even some of the SLTs at the hospital found it difficult, which was something he had seen when he had attended appointments with her. This is confirmed by the medical records.
75. On 23 February 2024 Danny Cullen provided a witness statement in which he described how he helped his mother clear her stoma if it got blocked. So far as her valve was concerned, he had been learning how to change it but he had not yet been able to do it successfully. He said that he found it very fiddly to get into the right place and he also struggled with the gel caps. He said that if the valve needed changing when he was looking after his mother, he would call either Anna or Dayne. If the valve became dislodged then they would have to attend urgently and he would have to insert a gastric tube into the puncture in the meantime. Although he was prepared for such an eventuality, he said that fortunately it had never happened whilst he had been on shift.

Evidence at trial

Inspection of the Claimant’s stoma at trial

76. On the morning of 5 March 2024, at the invitation of the Claimant and with the agreement of the parties, there was an opportunity for me to inspect at close range the Claimant’s stoma. I found this to be a very useful supplement to the witness evidence and the photographs that accompany Professor Homer’s and Mrs Howison’s reports. This was done in court. Present were myself, Mr Hough, Miss Mauladad, Miss Holmes, Ms Heathcote and Anna Crowley. In due course, Miss Holmes prepared a witness statement (15 March 2024) and then she and Ms Heathcote prepared a joint statement (31 May 2024) regarding this examination. In this part of my judgment, I am concerned principally with their observations rather than their opinions. They observed:-
 - i) Although the Claimant has restricted movement of her right dominant side, she was able to lift her hand to her stoma without visible tremor on the day of inspection.

- ii) The Claimant can see the entrance to her stoma using a small handheld mirror. There is no dispute that she has sufficient visualisation to clean away superficial secretions.
- iii) She can lift her chin to maximise the opening of her stoma. In this position, she reports restriction of view of the stoma and voice prosthesis. Ms Holmes agrees that her view is restricted, Ms Heathcote does not. I and counsel stood behind the Claimant whilst she did this, to gain an appreciation of her view of the stoma. I accept that it was not possible to replicate fully the Claimant's view, but with that caveat, it did appear to me that it would have been very difficult for her see inside her stoma and the inspection supported rather than undermined her evidence on this point.
- iv) The stoma is small in size and there is agreement that its size is suboptimal for performing valve or stoma care. For those present, it was necessary to come up close to the Claimant and, using a handheld torch, to look down into her stoma at a particular angle in order to visualise the valve which was deep/low within the stoma.
- v) Due to the angle of the posterior wall, the 'face' of the prosthesis was past the vertical, looking downwards into the airway. Ms Heathcote added her opinion that "the angle of the prosthesis is variable, depending on neck position and muscle tension, but is in general more downward facing". This variability of the position of the prosthesis is consistent with the lay witness evidence.
- vi) Ms Holmes stated that the angle of the prosthesis and the barrel limited ease of access and ability to visualise the valve, particularly for the Claimant but also for those present. I agree, having been one of those present. Miss Holmes said this was consistent with the evidence of the medical records (see the entry in the SLT records for 22 July 2022). Ms Heathcote agreed that the angles were not optimal.
- vii) A tail strap was still attached to the prosthesis. The distal end of the tail strap was secured to the neck underneath the baseplate (i.e. outside the stoma).
- viii) Miss Holmes commented that plastic tweezers have wide arms that would obstruct the view into the stoma on an attempt to remove secretions. She further observed that the Claimant has metal forceps that are thinner and obstruct less of the view into the stoma. Ms Heathcote did not disagree with these statements, rather she expressed opinions about whether secretions should be cleared with forceps and what the Claimant can and cannot see or do. Those are matters for me to consider, but there was no dispute as to Miss Holmes' description of the size and shape of tweezers and forceps. There can be no sensible dispute that the wider tweezers would obstruct more of the view into the stoma than the thinner forceps.

Claimant's evidence at trial

77. The Claimant was in the witness box for more than 3 ½ days, almost all of which were taken up with cross-examination. This unusually lengthy cross-examination allowed me an extended opportunity to assess her as a witness. In assessing her evidence, I have

considered not only the bare words spoken, which have been captured by the transcript, but also the circumstances and manner in which they were spoken. Cross-examination was much more hostile than the transcript conveys and the way the Claimant reacted to this sustained challenge and the spontaneity with which and manner in which she gave her answers are matters that I have taken into account when assessing her as a witness. She often answered questions quickly, sometimes before the question was complete, and sometimes without taking time to think about the question or the document she was being shown. I formed the view that this was partly due to disposition, partly due to general agitation at being in the witness box and partly a reaction to the hostile nature of the cross-examination. This tendency meant that there were times when she did not answer the precise question that had been put and there were times when she gave inaccurate answers, which took time to unpick and correct. It undoubtedly lengthened the process and complicated the evidential picture, but ultimately, in my view, it did not reveal dishonesty. Over the course of more than 3 ½ days of cross-examination, she impressed me as an honest witness.

78. The Claimant was cross-examined about stoma care.
- i) She said that no two days were the same. She said that she probably needs help about 50% of the time. She can do some of the stoma care herself because sometimes she can cough secretions up and she is able to wipe them away with a tissue. I observed her doing this at times during the trial. However at other times, with larger secretions, she cannot do this and she needs help from a carer. If a big secretion gets stuck, she has trouble breathing and she needs help to remove it. I observed her breathing become laboured on numerous occasions during the trial and she stepped out of court with Anna Crowley to clear her airway.
 - ii) She said that suctioning worked for what she called saliva, which I took to mean more watery mucus or similar. She said that she could use the suction machine, although it had been very difficult to learn how to use it at first. She can use it if the secretions come to the top of her airway and they are soft. But she cannot use suction if the secretions are deeper down within her airway or if the secretions are larger because they will not pass through the aperture at the end of the suction equipment. For larger secretions that got stuck in her airway, forceps were needed. She could sometimes, but not always, use forceps at the top of her stoma, but if secretions got stuck deeper down, then she could not do it at all and she relied on her carers to remove them using forceps. This was a daily occurrence and she always needed somebody there to help her with it.
 - iii) It was put to her in the course of cross-examination that she could remove secretions from deeper down using suction and using forceps and she was adamant that she could not.
 - iv) It was put to her that she had not complained to the SLTs about problems with suctioning and forceps and she said that that was because she could manage her stoma/airway with the help of her carers.
79. In closing, the Defendant quoted a number of the Claimant's answers at trial in relation to stoma care, submitting that they undermined her case. I shall deal with them here.

80. The Defendant submits that the Claimant conceded at trial that she did use forceps to remove secretions from deep within her stoma. The Defendant quotes the following answer by the Claimant:

“I'm left with no choice. It's me that's restricted. It's me that feels she can't breathe and that's scary. The reason I have to go into it with the forceps is because the cough is not bringing it up, because it's so big it's just not removing it.”

The Defendant further submits that the Claimant must be using tweezers herself, otherwise how would she know that they obscure the view into her stoma. The Defendant relies on the following answer by the Claimant:

“You see, the thing is, when they give you the tweezers, the tweezers are one long bit and they're blue and they're quite thick, so when you put the tweezers into my very small stoma you can't see anything else.”

81. It seems to me that these quoted answers have been taken out of context in a way that distorts their meaning. To put them in context, this part of the cross-examination began with the exchange:

“Q. One of the things that you told his Lordship and we have seen from your medical records, is you use forceps to go deep down to remove-

A. Well, I don't because I can't do it.”

The cross-examination that followed was about whether it was appropriate to use forceps to go deep down into the stoma to remove secretions and whether the SLTs had advised against it. It was being put to the Claimant that it was inappropriate and she was saying that you had to do it. It was in the context of this questioning that the Claimant gave the quoted answer. The questioning was not about whether it was the Claimant or her carer who used the forceps and to characterise her answer as a concession as to who held the forceps is not correct. The cross-examination continued and the Claimant was asked about using a nebuliser and she said that she used a nebuliser every morning but there was not time to set up a nebuliser when she was finding it difficult to breathe and she needed secretions removed. She then said this:

“A. Sorry. I am telling you that I can't clean them big secretions up in my throat. It's scary. I get very laboured in my breathing, and it's very, very scary. It really is very, very scary. They won't come up. I can't get them up. It's the only way I can get them up, or we can get them up. And with a torch I can't see right down in because I have to put my head back. Anna has to pull the secretions out because they're below the valve.”

This was the only answer that was unambiguous as to who held the forceps and it was Anna Crowley, not the Claimant. The evidence was remarkably consistent from all the witnesses on the question of who removed secretions from deep within her stoma using

forceps. The evidence was that this is something that is performed by the Claimant's carers, not by the Claimant herself.

When the cross-examination continued, I raised with counsel whether there were any further instances in the very voluminous medical records of the Claimant having been advised against the use of forceps, other than the single reference that had been put to her, and counsel did not identify any other instances. I then asked counsel if the records showed the SLTs advising the Claimant to use an alternative method of removing secretions and counsel stated that we had heard in evidence the previous day that the hospital had given the Claimant tweezers. It was then that the Claimant explained that tweezers are unsuitable because they are thick and obscure the view of the stoma. This was not a concession that she removes secretions from deep within her stoma or that she can visualise within her stoma. It was a comment on the suitability of the two types of instrument and it is notable that the Claimant's observations about the disadvantages of tweezers are entirely consistent with the expert evidence.

82. The Claimant was also asked about care associated with her voice prosthesis.
83. She was asked about cleaning the valve, which has a little hole in the middle of it. She said that when this becomes blocked with mucous or debris, it requires something a little bit like a pipe cleaner to be inserted into the centre of the valve and rotated in order to clean it. She said that in order to do it, you have to have a mirror and a torch and you cannot do it with one person. She said that occasionally she can do it depending upon the position of her valve, but she cannot always do it. She said you had to be able to visualise the valve in order to do it. Her evidence as to the variability of the position of her voice prosthesis is consistent with the opinion evidence of Ms Heathcote and her evidence as to the need to be able to see the valve in order to clean it is consistent with the expert evidence generally.
84. She was asked about valve changes. There is no dispute that historically this has been done at the hospital by the SLTs. More recently, the evidence is again clear that Anna Crowley and Dayne Cullen have been able to do this away from the hospital. It was put to the Claimant in cross-examination that she could change the valve herself and she said no she could not. She commented that even the SLTs find it difficult, which is confirmed in the medical records. She was asked about various aspects of her valve change.
 - i) She said that it is very difficult for her to see her voice prosthesis and her puncture, although sometimes she can see something. She said that it moves and her ability to see it depends on the day and how far it has gone down in her neck.
 - ii) She said that you would prepare the new valve before you take out the old one. If you did not do that, you would have to use a dilator which the SLTs like to use, but which she and her carer very rarely used. She described the dilator as being difficult to insert and if they did do it, it was done by Anna or whoever was helping her. There had been times when she had managed to insert the dilator herself with assistance from her carers, but she would not attempt it on her own.

- iii) In order to prepare the new valve, it has to be placed onto the end of a T bar stick. She said that this is a difficult thing to do and sometimes you can do it 10 or 12 times and the bar breaks.
 - iv) The next step is to insert the valve into a gel cap. This is done outside the stoma, before any attempt is made to place it into the stoma and into the puncture. The evidence from several witnesses was that this is a very fiddly process. The Claimant said that she finds it particularly difficult. The valve itself has to be folded over and squashed and held in that squashed position whilst being pushed into the fragile gel cap. The gel caps can break, split or melt. Successfully getting the valve into the gel cap is not easy and the Claimant said that this was something that even the SLTs sometimes cannot do. She said that sometimes you can be there for an hour just trying to get the gel cap on. If it goes in first time, everyone is surprised.
 - v) In order to help her carer see into her stoma, she inserts a 'lary tube' into her stoma, which helps to enlarge it slightly. She is able to do this.
 - vi) The old valve then has to be removed. The Claimant said that if she has left the tag on the old valve, then she can pull the old valve out.
 - vii) The new valve then has to be pushed into the puncture site and left in place until the gel cap dissolves. It takes several minutes to dissolve and it pops when it does. The placing of the new valve into the puncture site or tract was something that the Claimant was asked about. It was put to her that she could do it herself and she said no, it was something that her carers did. She said that the position of her puncture is such that she finds it very very difficult to see her valve. When the valve is taken out, it becomes even more difficult for her to see the puncture because she cannot tell the difference between the puncture and the surrounding skin. This is all made even more difficult by the fact that she has to have her head tilted quite far back to allow access to the stoma and the puncture. She said she had tried to do put a valve in herself but when she had attempted it, it had gone wrong. She said that for all these reasons, it was her carer who would put the new valve in the puncture site/tract.
 - viii) Once the new valve is in place, she has to have a drink as a test to make sure that it is not leaking.
85. The Claimant's evidence was that she did not change her own valve. She accepted that there were elements of the process that she could do with a greater or lesser degree of difficulty. The only tasks that she said she could do easily and without assistance were the insertion of the lary tube and the removal of the old valve that still had its tag attached. Otherwise, all tasks were either very difficult or simply too difficult for her to do. She said that she always changed her valve with a carer.
86. In closing, the Defendant quoted a number of the Claimant's answers in relation to her voice valve, submitting that they undermined her case. I shall deal with them here.
87. The Defendant submits that the following answers contradict the Claimant's assertion that it is her carer who inserted her voice valve.

“Q. If Ms Mauladad is right and what the note says is that the role of the carer is simply to confirm that you have managed to put the prosthesis in place, so, in other words, you do the placing but the observer, the carer is the observer who tells you, "Yes, you've got it right, it's in”

A. Yeah, but it doesn't always happen like that.

Q. Is that correct? Is that what is happening?

A. It doesn't always happen like that, no.”

88. The quoted exchange has been taken from the transcript, yet it omits what went before and stops in the middle of a sequence of related questions and answers, with the result that it does not properly reflect the Claimant’s evidence. The Claimant was being asked about Freya Sparks’ entry in the medical records dated 21 February 2024 and she had said that “visual confirmation of the prosthesis placement in the tract” meant the carer actually placing it into the puncture. She was challenged about this and she reiterated more than once that it meant that Anna put the valve into the tract. It was accepted by counsel that the Claimant had not told Freya Sparks what to write, and the Claimant said that she had just asked Freya Sparks to explain that she did not do it on her own. We then pick up the quoted questions (from me) and the Claimant’s answers. I set out below the entirety of the exchange.

“Q. If Ms Mauladad is right and what the note says is that the role of the carer is simply to confirm that you have managed to put the prosthesis in place, so, in other words, you do the placing but the observer, the carer is the observer who tells you, "Yes, you've got it right, it's in”

A. Yeah, but it doesn't always happen like that.

Q. Is that correct? Is that what is happening?

A. It doesn't always happen like that, no.

Q. Is it you who is placing the valve in place?

A. No, the carer places it the tract.

Q. Right.

A. I find it very difficult to find the tract. I find it very, very difficult to see it.

Q. What is being suggested to you is that you are putting it in the tract and the carer is just telling you that you have got it in the right place?

A. No, it doesn't happen like that. The carer puts it in the tract.”

89. Looking at the full sequence of questions, it seems to me that the Claimant's evidence at trial was that it was her carer who put the valve in the tract/puncture.
90. The Defendant submits that the proposition that she could insert the valve in the tract is supported by what happened on a trip to Rome in 2023. In fact the Claimant's evidence was that she travelled to Rome with a friend called Jackie. Jackie is not one of her regular carers, but she knows how to help her manage her stoma. When the valve came out during the trip, she and Jackie tried to put it back but were unsuccessful in getting the valve back in. This is consistent with the SLT records dated 13 November 2023. To my mind, the fact that the Claimant and Jackie tried unsuccessfully to put the valve back in, in circumstances where there was no one else on hand to assist, does not indicate that the Claimant is capable of changing her valve herself. The fact that she was unable to change her valve in Rome, when there was every incentive for her to do so if she could, is strong evidence of her inability to change her own valve.
91. It was also submitted that the presence of a mirror in the bag of equipment that accompanies the Claimant is significant because the carers do not need a mirror, the implication being that the Claimant must be using it to change her voice valve and/or clean her stoma. This submission derives from an observation made by Ms Heathcote (whose evidence I consider below) for the first time when she was recalled to give evidence on 21 June 2024 and it was said right at the end of cross-examination. In fairness to Ms Heathcote, she did not say that the presence of a mirror means that the Claimant can change her voice valve and clean her stoma. What she said was "I presume she carried the mirror to perform toilet to her stoma". This seems uncontroversial. Although the Claimant was not specifically asked about the mirror, nor were any of her witnesses, there was some evidence of the use of a mirror by the Claimant and other evidence from which such use can reasonably be inferred. For example, the Claimant said at the inspection of her stoma on 5 March 2024 that she can see the entrance to her stoma using a mirror. The Claimant accepts that she can use suction and forceps at the entrance to the stoma, all of which requires her to be looking in a mirror. What she says she is unable to do is to see into her stoma well enough to change her voice valve or reliably clean her voice valve, and she cannot see down into her airway to remove secretions. Anna Crowley gave evidence that there were times when she would hold the mirror so that the Claimant could see to take hold of the tail of the old valve (which sits outside the stoma) and pull out the old valve. These tasks would all require a mirror. It is not difficult to envisage a mirror being useful for general skincare around the stoma, for use in connection with HME filters, etc. Given the vulnerability that her stoma represents, it would be extremely surprising if she did not carry some means of being able to see as much of it as possible.
92. The Defendant asserts in closing that the evidence of the Claimant is that she can change the valve but she needs help. It seems to me that this assertion is the wrong way round. The evidence of the Claimant is that her carers can change her valve, with some help from the Claimant.
93. The Defendant also submitted in closing that "the claim for 24-hour care, as set out in the Claimant's original Schedule of Loss was dishonest and the Claimant knew it was. She conceded she did not say that she required such care." This was a point upon which Ms Palmer also relied. Again it does not reflect the full evidential picture. What the Claimant said, when being questioned about her Schedule of Loss, was "I never said I

needed 24-hour care. Everyone else has said it. I just can't manage on my own. I just know that." Later in cross-examination, the Claimant was asked "do you think you need help 24 hours a day?", to which the Claimant responded "I need help, I need help all the time." Counsel asked "24 hours a day?" and the Claimant responded "well, there could be half an hour then and half an hour there, but somebody has to be with me all the time" and she went on to describe how scary it was when big secretions got stuck and she had trouble breathing. Contrary to the Defendant's submission, it seems to me that the Claimant's evidence was clear that she was saying she needed someone with her all the time.

94. There were other issues about which the Claimant was cross-examined and in respect of which she was accused of dishonesty. It is convenient to deal with them here.
95. The Claimant was cross-examined about her claim for gratuitous care on occasions prior to September 2021 when she was away on holiday. What was being put was that she went on holiday without her son Dayne, yet she was making a claim for gratuitous care which he could not have been providing. Although it was not a pleaded allegation of fundamental dishonesty, it was put to her with some vigour that she had been dishonest and it is something that is pursued by the Defendant in closing submissions. I consider the evidence of it here. The Claimant was taken to the words in the preamble to the care claim: "From January 2017, the Claimant's son became her full-time carer." She agreed that the son being referred to was Dayne. She was then cross-examined on the basis that she had claimed gratuitous care when Dayne was not present, specifically when she was on holiday without him. She was not referred to that part of the same paragraph where it said that he was assisted from time to time by other family members and friends, nor was she referred to a statement to similar effect in the previous paragraph, nor was she referred to that part of her Schedule of Loss where she made a claim in respect of holiday expenses where it said that after her laryngectomy, when she was well enough, she had been "encouraged to resume travelling but she needed to be accompanied by people able to provide care and assistance. She has managed this by relying on family on some trips and for others by goodwill of friends and employed carers willing to accompany her using their own holiday, not being paid for off duty hours and sharing rooms." It was against this background that it was put to her that she was being dishonest. For example, it was put to her that when she travelled to Marrakesh in 2017/18, she knew she was away on holiday and she knew that she was not being provided with 24/7 care by Dayne, and so her claim for 24/7 gratuitous care was dishonest. The Claimant replied that that was "ridiculous". In fact the Claimant's evidence was that she travelled to Marrakesh on two occasions. On the first occasion she travelled with a friend called Anne Docherty who the Claimant said had experience of looking after her own son with cerebral palsy and who specifically knew how to look after the Claimant. On the second occasion she travelled with Annie Courtney, who the Claimant said knew how to do her care from having been shown how to do things by Dayne Cullen, Anna Crowley and the Claimant herself, and who subsequently became one of her regular carers. It is not necessary to analyse each trip in the period prior to September 2021 in this way. The Claimant's evidence, which I accept, was that each trip was taken with at least one other person who was able to help her manage her stoma. There is no evidence of solo travel. On occasions the other person was someone like Anne Docherty, a friend who had relevant skills and was shown what to do, but for the most part the other person was one of her regular carers using their own holiday to accompany her. On some occasions it was one carer who accompanied her, on other

occasions, when the trip was longer, she travelled in a group and more than one carer was with her. An example of the latter is the trip in July 2022 to celebrate Jodie's 40th birthday, during which the Claimant posted on Facebook: "would not be able to do it without my lovely, dedicated carers you are all amazing". It seems to me that this is entirely consistent with what was being asserted in the Schedule of Loss. The claim for gratuitous care was not limited to the care provided by Dayne Cullen, although he undoubtedly provided the bulk of such care. The claim extended to gratuitous care provided by family and friends and it was explained how this worked in relation to holidays. The allegation as formulated in closing submissions is that "the Claimant has dishonestly claimed gratuitous care provided by her son, Dayne Cullen, when such care was not provided". I do not accept that submission for the reasons given.

96. She was also cross-examined about carer's allowance. What was being put was that Dayne Cullen had been in receipt of carer's allowance but credit had not been given for it in the Schedule of Loss. The Claimant said that well before she received any funding for her care, she and Dayne were advised to apply for carer's allowance for Dayne. She said it was a very small amount of money. When she started to get funding for some of her care, he continued to get carer's allowance because he was looking after her for more hours than he was paid for. She agreed that he continued to get carer's allowance until July 2022. It follows that Dayne was receiving carer's allowance during the period up to September 2021, in respect of which she is making a claim for his gratuitous care. It was not suggested to her that she had made a positive assertion that he did not receive carer's allowance. Instead, it was put to her that she should have declared it and had not done so, to which she replied "declared it to who?". It was put to her that she should have put it in her Schedule of Loss and she said that she had not thought it was relevant and it had not crossed her mind. It was being put to her that she had mentioned the funding that she received from the local authority and then CHC, but not the carer's allowance and she said that the CHC funding was in her mind all the time because she gets 24-hour care and she pays her carers out of that funding. The carer's allowance, by contrast, had stopped by the time the claim was being formulated. I observe that, to a lay person, it would not necessarily be obvious that this had a bearing on her claim. Having listened to her evidence, I am satisfied that there was no deliberate concealment of the carer's allowance and that if she had been asked about it by her solicitors, she would have told them. I do not find there to have been dishonesty in relation to the carer's allowance.

Anna Crowley's evidence at trial

97. Anna Crowley is a carer. I found her evidence in relation to the care that she has provided to the Claimant to be clear and convincing. She was less confident when asked about dates or documents. I did not find this surprising. She is a carer, not a lawyer. Overall, I found her to be an honest and guileless witness.
98. She was cross-examined about stoma care. She had described this in her witness statement. She agreed that they use the nebuliser. She said that the Claimant tried to cough things up and if she was able to do so, they could be wiped away from the entrance to her stoma using a tissue or a swab. But sometimes the Claimant would cough and cough and cough but the secretions would not come up sufficiently far to enable her to do this. It was then that she required Anna Crowley to remove them because the Claimant would not go inside her stoma to remove secretions. That was something that she, Anna Crowley, did. She would use the suction machine, but if the

secretions were thick or sticky and got stuck inside the stoma, then she would remove them using the forceps. She said that she does it because she is not afraid of it and because the Claimant cannot do it for herself because she cannot see down inside her stoma. She was asked how far down she was talking about when she spoke about removing secretions with forceps and she held up her thumb and forefinger and counsel suggested she was indicating an inch and she agreed. It seemed to me that she was indicating slightly more than an inch, but I do not think anything turns on that.

99. She was cross-examined about valve changes.

- i) She said that she had been caring for the Claimant for a long time and she attended the SLT appointments with the Claimant. She was interested in learning more about how to care for the Claimant and so she took an interest in the valve changes that the SLTs carried out and was shown what to do. She would watch what they were doing and she would ask lots of questions because she wanted to make sure that she knew what she was doing because she knew that the Claimant could not do it for herself.
- ii) She said that no two valve changes were the same. Every day is different.
- iii) She said that the Claimant can remove an old valve. Anna Crowley gets the mirror and the light into the right position and the Claimant can see the tag and pull out the old valve.
- iv) She said that the Claimant can push in the lary tube, which is a tube that stretches the stoma so that she, Anna Crowley, can see into it more easily.
- v) She said that she, Anna Crowley, fits the gel cap onto the new valve. It is fiddly and the Claimant finds it incredibly difficult and most of the time cannot manage it. Anna Crowley said that even she found it difficult, although sometimes she can get it first time.
- vi) She said that she, Anna Crowley, would then insert the new valve into the puncture. She said that the Claimant could not do this for herself and that she never had done it for herself. Anna Crowley said that even she found it hard sometimes but she persevered with it. She confirmed that no two valve changes are the same and sometimes it is more difficult than at other times. She explained that the Claimant has to put her head up and it is hard for her to see so she, Anna Crowley, has to insert the valve. She described the very first time that she had done it. She could not remember the date but she remembered that that the Claimant's valve was leaking and for some reason the SLT team could not do a valve change that day and as a result the Claimant panicked a bit. Anna Crowley was there and she felt like it was her duty to help the Claimant and so she and the Claimant decided to change the valve themselves, but she, Anna Crowley, did all the changing. She said that she, Anna Crowley, was terrified because it was the first time that she had actually had to change the valve. The Claimant had her head up and Anna Crowley was trying to put the valve into the puncture and she was saying that she could not see and so she said that the Claimant took her hand and just sort of guided her and she, Anna Crowley, pushed the valve in and it held. There was a slight popping sound which meant that it was in. Anna Crowley said that she was pretty amazed that she had

managed it. When she was asked what she meant by the Claimant ‘guiding’ her hand, she said that the Claimant had just held her hand because she was nervous and her hand was shaking and the Claimant held her hand to steady it. She reiterated that inserting the valve was something that she had never seen the Claimant do for herself and it was something that the Claimant could not do for herself.

100. She was asked about handovers between carers and continuity of care. She said that there would always be a carer there. She said that at the beginning of her shift, she would see the carer who was coming to the end of the previous shift. At the end of her shift, she would see the next carer who was starting the next shift. She said that they were always there. Whatever was going on, there was always someone there.
101. Her evidence was, as I have said, clear and convincing. However in closing the Defendant submitted that none of Anna Crowley’s evidence can be relied upon because, the Defendant submitted, she had lied in her witness statement about being present on a flight to Jamaica with the Claimant and providing care to the Claimant during that flight. The Defendant submitted that not only can her evidence not be relied upon, but she and the Claimant must have colluded in this lie and this is a further example of fundamental dishonesty on the part of the Claimant. The evidence in question appeared in paragraph 19 (of 21) of Anna Crowley’s statement dated 22 July 2022. In the course of cross-examination, she was taken through her witness statement paragraph by paragraph. When she was asked to turn to paragraph 19, she looked at it and her immediate reaction was that it was wrong. Although she and her partner Trevor had gone to Jamaica with the Claimant, she and Trevor had been on a different flight to the Claimant. They had gone to celebrate the 40th birthday of Trevor’s daughter, Jodie. The Claimant had travelled separately with Janette Collins (Trevor’s sister and another of the Claimant’s carers). Anna Crowley did not know why it said she had been on the flight with the Claimant. She said that she did go on the trip, she did provide care to the Claimant on the trip and she described how the Claimant’s valve had been leaking whilst they were in Jamaica and how they had tried to stop the leak and how the Claimant had had to use thickener, but she was clear that she had not been on the flight with the Claimant. The Defendant does not dispute the honesty of Anna Crowley’s evidence about this at trial, but submits that she must have deliberately lied in her witness statement and that there can be no other explanation. It seems to me that there may well be other explanations, the most obvious of which is that whoever drafted the statement had misattributed things to Anna Crowley, that had in fact been said or done by someone else, and included them in the statement which she had signed without reading it properly. In considering the Defendant’s suggestion that she must have deliberately lied in her statement, I have considered whether such a conclusion is consistent with the way that she volunteered the inaccuracy. It was not a concession that was wrung out of her in cross-examination. It was her spontaneous response to seeing the contents of paragraph 19 and it had the overwhelming ring of truth about it. If she had set out to mislead the court in her witness statement, I would have expected her to confirm that paragraph 19 was accurate, but she did the opposite. So far as other explanations are concerned, it is not fanciful to think that whoever prepared the statement had also spoken to Janette Collins as part of the evidence gathering exercise and had misattributed her evidence to Anna Crowley. It is certainly the case that whoever drafted this paragraph had a poor grasp of who was who, because elsewhere in paragraph 19 it says that she travelled to Jamaica to be part of a celebration for “a

friend of [the Claimant]”. I am quite sure that Anna Crowley would not have described Jodie as “a friend of [the Claimant]”. Taking the evidence in the round, I do not find that Anna Crowley lied about the trip to Jamaica in her witness statement. I find that the statement was inaccurate and she failed to read it carefully before signing it, but I do not find that she was dishonest. On the contrary, and somewhat ironically, I find that the way in which the inaccuracy in paragraph 19 came to light provided compelling evidence of her honesty.

Dayne Cullen’s evidence at trial

102. Dayne Cullen gave evidence. He had seen his mother being subjected to prolonged and hostile cross-examination and he was clearly nervous. Under similar cross-examination, there were times when he found it difficult to focus, particularly when asked about dates and documents. His evidence in relation to the care that he provides to his mother, and which I considered to be the most important aspect of his evidence, was much more confidently given, although even then he stumbled over his words and it was necessary to make due allowance for nerves. Listening to his evidence, it seemed to me to be abundantly clear that he was honestly describing the care that he has provided and continues to provide to his mother.
103. He said that his mother could not fully manage her stoma and he described helping her to manage her stoma and airway. He described how his mother produces phlegm and secretions which she tries to cough up, but she cannot always clear her airway with a cough and she can feel phlegm or secretions obstructing her airway. He said that he helps her with the things that she cannot do for herself, such as going down into her stoma and cleaning it. He said that he uses a torch and he uses swabs, suction equipment and forceps. He also helps her with the nebuliser. He said that he makes sure that her stoma is clean and “it all looks good”. He said that some days are better than others, but on a bad day he could have to help her dozens of times. He said that he also looks after her more generally, applying barrier cream to the skin around her stoma which becomes sore and dry as a result of the glue they use for the baseplate, making sure the instruments are clean and sterile, making sure they have enough equipment etc. He also gave evidence that he can change his mother’s voice valve and he had done it “the other night”. He was asked how long it takes to change her valve and he said that it depends. He said “it could take ages to get the gel pack in. The position. Whether or not it’s in the morning or evening, whether the back of her neck is straight, whether it’s tilted. It could be quick or it could be prolonged.” Pausing there, this description of the variable position of the puncture/voice prosthesis is consistent with the evidence of other witnesses and the expert evidence. He said that he and Anna Crowley were the ones who could do it. He was not cross-examined on the different elements of a valve change and on who did what. He also said that he would clean her voice valve with what he described as the pipe cleaning brush, and he explained how the valve becomes stiffer when it is on the way out and you can feel this loss of elasticity when you put the pipe cleaning brush into the valve to clean it.

Danny Cullen’s evidence at trial

104. Danny Cullen gave evidence. He seemed to me to be an entirely straightforward and honest witness. I have dealt with certain aspects of his evidence elsewhere, such as the surveillance footage and the extent to which the Claimant looks after his children/her

grandchildren. His evidence of the care that he provides to his mother, which I have summarised earlier in this judgment, was not challenged and I accept it.

Defendant's surveillance evidence and related lay evidence

105. The Defendant arranged for surveillance to be carried out on 8 days in January 2024. The resulting footage is in evidence and is relied upon by the Defendant and the Claimant and her witnesses were cross-examined about it at trial.
106. The surveillance evidence in this case is somewhat unusual. Surveillance evidence is typically adduced to demonstrate that a Claimant has greater physical capabilities than he or she has asserted. That is not this case. In this case the Claimant says that she needs and has 24-hour care. The surveillance evidence is adduced in support of the Defendant's allegation that the Claimant has been dishonest about the care that she receives and she has not been receiving 24 hour care. The Defendant says that the surveillance evidence shows that carers are not coming and going from the Claimant's home address. In that sense, it seeks to prove a negative. That being so, there are a number of very unsatisfactory aspects to the surveillance evidence: –
 - i) The surveillance footage itself is not continuous throughout each period of surveillance such that it would, as a stand-alone piece of evidence, demonstrate who did and did not come and go at the Claimant's home. The surveillance footage that we do have, and I am told that it is the entirety of the footage that was taken, is minimal.
 - ii) There is no evidence from the surveillance operatives to the effect that they kept the Claimant's house under constant surveillance during their shift and captured everything that happened and that if it is not on the footage, it did not happen.
 - iii) Although there is a proforma statement from each of the operatives stating "I obtained video evidence, where possible, of the events that occurred", this is not supported by the evidence. By way of example, there are events recorded in the surveillance logs that the operative purports to have seen, but has not filmed. By way of further example, there are numerous occasions of the operative filming something, but only filming the last few seconds of what was obviously a much longer episode, often in a way that makes it impossible to identify the person being filmed and without any explanation as to why the longer episode had not been filmed. These omissions reinforce concerns about the incomplete nature of this evidence as a whole.
 - iv) It appears as though, on occasions, the surveillance was being conducted from a significant distance and that, on occasions, the surveillance operative moved to a different location during the period of surveillance, with the obvious risk that the surveillance was not continuous.
 - v) Whilst there is some footage of cars parked outside the Claimant's home, it is haphazard and often appears to be incidental. There was no attempt on any of the days to take a comprehensive inventory of the vehicles parked in the road at various times, such as would have been valuable in identifying whose vehicles were present at what time.

- vi) The period of surveillance often starts either close to, or well after, the start of the carer's day and ends either well before, or close to the end of the carer's day, with the inevitable risk that handovers have occurred outside the period of surveillance.
107. In these circumstances, I accept that if something is shown on the footage, that is determinative of it happening. However I do not accept that the absence of something on the footage is determinative of it not happening.
108. I now turn to the footage itself and the witness evidence associated with it.
109. On the first three days, the Claimant was away, with Annie Courtney, visiting family in Germany. Unsurprisingly the footage did not observe her or her carers coming or going from the property. On Thursday 11 January 2024, the surveillance ended at 15:02. The Claimant's evidence, which I accept and which is confirmed by the flight booking documentation, was that she and Annie Courtney were travelling back that day. Their flight was not due to land at Heathrow until 13:30 and the Claimant's evidence was that they in fact landed at about 14:30. They then collected the Claimant's car from the park and ride and drove back to the Claimant's house, arriving well after the surveillance had ended for the day. Annie Courtney returned home that night, but Dayne Cullen was at home with his mother. In passing, I observe that despite this being a short haul trip and despite it being a trip to stay with family, it is conspicuous that the Claimant was still accompanied by one of her carers.
110. Friday 12 January 2024. The Claimant's evidence, which I accept, was that her carer Deanna Sharpe had been running late that day and Dayne Cullen had waited until she arrived before leaving for work. Deanna Sharpe had arrived and Dayne Cullen had left well before the surveillance commenced at 10:18. At 11:22 Deanna Sharpe is seen at the boot of the Claimant's car (which had been parked in the road when the surveillance began), fetching the Claimant's suitcase from her Germany trip and taking it inside. It is surprising that there is no footage of her emerging from the house and walking to the car. I am satisfied that that is what she did, but I do not understand why it was not captured if the operative had been paying close attention to the property. At 12:38 Janette Collins is shown arriving with a young man and she is seen leaving again at 12:46. At 13:43 Deanna Sharpe comes out and puts something in the rubbish. At 13:46 the young man leaves. The evidence of both the Claimant and Dayne Cullen was that he returned home at about 14:30. He explained how, on a Friday, he finishes at 14:00 and it takes about half an hour to get home. He travels to and from work by bicycle. The Claimant's evidence was that he uses "bikes that you have to pay to ride". His arrival home is not captured in the surveillance footage. However when Deanna Sharpe left the property on foot at 14:57 and she was filmed walking away from the property, she walked past a parked Lime bicycle that was parked close by. Deanna Sharpe then turns the corner at the end of Morton Road and walks away from the camera along the adjacent road. It is apparent that there has been activity at the front door that was not captured by the surveillance operative whilst he was filming Deanna Sharpe walking away. The last shot of her is at 14:58:47 and the next shot is at 14:59:04 and it shows the Claimant already standing outside her front door talking to someone out of shot at the foot of the steps leading to her front door. After a short conversation, that person walks up the steps and she hands him some cash and he leaves. The evidence was that this man is an electrician called Mark with whom Dayne Cullen works. As Dayne Cullen described it, he is a plumber and Mark is an electrician and they work in tandem

when it comes to jobs. Mark was buying items from a wholesaler and he was collecting money from Dayne Cullen in order to do that. Dayne Cullen thought he was probably having a bath, having not long returned from work, which was why his mother had answered the door rather than him. The footage ends at 16:05. I have considered carefully whether I accept the evidence of the Claimant and Dayne Cullen that he returned home before Deanna Sharpe left. I accept that he waited until she arrived that morning before going to work. I accept that his normal routine on a Friday meant that he normally returned from work at about 14:30 and that was the specific recollection of the Claimant on this particular day. I reiterate my observations about the incomplete nature of the surveillance footage and how the absence of something on the footage is not determinative of it not having happened. I remind myself that in relation to 24 January 2024 (see below), the footage actually captures the overlap between Anna Crowley arriving and Dayne Cullen leaving, which is consistent with what he and the Claimant say about what happened on 12 January 2024. Taking this evidence in the round, I find on balance that Dayne Cullen did arrive home at about 14:30 on 12 January 2024.

111. On Saturday 13 January 2024, the evidence from Danny Cullen was that he was at home with his mother all day. His evidence was corroborated by the presence of his van, clearly visible in the footage, parked outside the house when the footage begins and still there when it ends. He does not live within walking distance of his mother and the presence of his van is, in my judgement, good evidence of his presence at the property. His evidence was that he did not come over on the Friday night, so that he could enjoy a Friday night off, but he took over from Dayne early on the Saturday morning. He spent most of the weekend at his mother's house. He said that they are both big fans of snooker and he recalled that they watched the snooker together. His evidence was credible and was supported by the footage.
112. On Saturday 20 January 2024, both the Claimant and Dayne Cullen gave evidence that he was at home all day with the Claimant. There is nothing in the footage to contradict this evidence.
113. On Tuesday 23 January 2024, the evidence of Anna Crowley was that she arrived before 08:00 and stayed all day, leaving between 17:00 and 17:30. That was consistent with her evidence of her usual working hours on a Tuesday being 08:00 to 17:00. The surveillance did not start until 08:28 and ended at 17:00. It did not capture her arrival or departure. The Claimant gave evidence that she thought she and Anna had gone to the door together at about 16:00 and Anna had left and Dayne arrived home around 16:30. When she was cross-examined it was suggested to her that Anna had not been there at all that day and she was adamant that Anna had been at the house that day. She thought that Dayne had come home at about 16:30 because that's when he gets home from work. When she was pressed about Dayne's arrival home, she became more entrenched, but her initial answer seemed to me to be based on what normally happened rather than on a specific memory of that day. I think she was probably wrong about the timings. I prefer the combined evidence of Anna Crowley and the footage. I accept her evidence that she arrived before 08:00 and I conclude that she was still at the house when the surveillance operative left at 17:00.
114. There is one further matter which arises from the footage from 23 January 2024 and which it is convenient to address here. At 16:08, the Claimant can be seen at her front door, already bending forwards and doing something with her hands in front of her. The

view of what she is doing is partly obscured, but the Claimant said she was putting something in the rubbish and that is consistent with what can be seen. In the care experts' joint statement dated 26 June 2024, Ms Palmer said that the Claimant had "advised MP that she cannot bend over as this blocks her stoma. However, she was seen to bend over on surveillance." Ms Palmer was cross-examined about this and it was put to her that, when the Claimant bends forward on the footage, her stoma was not occluded. She replied "that's still being able to bend. She told me she cannot bend" and in re-examination she was shown the footage and she said it showed the Claimant's stoma occluded. In considering this alleged inconsistency, I start by considering Ms Palmer's assertion that the Claimant said she cannot bend over. The source of this assertion is to be found in Ms Palmer's report dated October 2023, which was based on an assessment in October 2022. In that report, she did not record that the Claimant cannot bend at all, she recorded that the Claimant could not bend forward to shave her legs. That is a personal care task that would involve the Claimant looking down and towards her body, a position that would tend to obscure her stoma, and doing so for much more than a few seconds. By contrast, in the footage the Claimant is seen leaning forwards and initially her head is in line with her back. In other words, her body, neck and head are in the same relative positions as they would be if she were standing up looking straight ahead, but she is leaning forward and therefore looking down. She is in that position for less than 2 seconds. She then looks up, moving her chin further away from her chest, and then stands up, this movement taking about a second. Throughout the whole sequence, which lasts for 3 seconds, there is nothing in the relative positions of her head and neck that would suggest that her stoma would be obstructed or blocked. I do not agree with Ms Palmer's comment that it shows the Claimant's stoma being occluded. In my view, an assertion that she cannot shave her legs is not inconsistent with what can be seen on the footage. Moreover, if it is approached in a fair-minded fashion, it is obviously not inconsistent.

115. Wednesday 24 January 2024. The footage begins at 08:55. At 09:23 it shows the top of someone's hat for a few seconds as that person goes into the Claimant's address, yet there is no footage showing that person arrive or from which they can be identified. We know from other evidence that it is Anna Crowley. She was not due to be working that day, but the Claimant had postponed her trip to Scotland by a day because of storms and so she needed Anna Crowley to come in, which she did, a bit later than usual. She arrived by car, but there is no footage of the car being parked, or of her getting out or of her making her way to the front door. The next piece of footage, timed just over 2 minutes later, shows someone's hand placing something on the driver's side dashboard of a car. That is all it shows, despite the fact that the surveillance operative's attention had been drawn to activity at the house only 2 minutes earlier. Based on other evidence, it is a reasonable inference that it is Anna Crowley, but there ought to have been footage of her going to and from the car, from which she could have been identified. The next piece of footage, timed 14 minutes later, shows someone in a high-visibility jacket cycling away from the house. By the time they are filmed, they are already at some distance from the house with their back to the camera. Again there should have been footage of them emerging from the property and cycling off, from which they could be identified. We know from other evidence that it was Dayne Cullen, who had waited until Anna Crowley arrived before leaving for work later than usual, which is entirely consistent with the Claimant's case and with Anna Crowley's evidence about overlap between carers. The next piece of footage, timed almost 2 hours later, shows someone in the driver's seat of Anna Crowley's car driving away from the front of the house.

Again there is no footage of her leaving the house or getting into the car. The footage does not show her returning, but her evidence, which I accept, was that she did return about 15 minutes later. She remembered Annie Courtney arriving. The Claimant's evidence was that Annie Courtney arrived at was about 12:00. At 11:55 the footage shows the Claimant going back into her house. It is clear that something, which has not been captured, has caused the Claimant to open the front door, emerge from the house and then turn to go back in. On the available evidence, it seems to me to be probable that this was Annie Courtney arriving. At 12:17 the surveillance log records a parcel delivery to the house, but does not record who answered the door and the incident is not captured on the footage. At 16:00 the footage shows an unidentified stretch of pavement with some parked cars. It is not the pavement outside the Claimant's house where her car had been parked earlier that day and it does not assist in determining whether her car was still there. Indeed, there is no footage after 11:29 from which it is possible to say whether her car was there or not. At 17:00 the surveillance log records a man leaving the address and getting into a taxi. This is not captured on the footage, and the man's earlier arrival is neither recorded in the log nor captured on the footage. The footage ended at 17:00, by which time the Claimant had not left yet. The Claimant's evidence was that she and Annie Courtney drove to Annie Courtney's house in Buckinghamshire that evening, as they were going to Heathrow the following morning to travel to Scotland where the Claimant has family. Her evidence of Annie Courtney coming to collect her is consistent with Dayne Cullen's evidence of the usual arrangements for such a trip and the flight from Heathrow the following morning is confirmed by the flight booking documentation.

116. In closing, in addition to the surveillance footage itself, the Defendant invites me “to draw an adverse inference against the Claimant for failing to adduce evidence from any other carers, in particular those alleged to have been present during the period of surveillance”. In support of this invitation, the Defendant relies upon the case of *Wisniewski v Central Manchester Health Authority* [1998] PIQR P323. That was a birth injury case in which the plaintiff alleged that a nurse had been negligent in failing to inform a doctor of the plaintiff's tachycardia, alternatively the doctor had been negligent in failing to attend upon the plaintiff's mother. One of the issues in the case was what the doctor would have done if he had attended. The doctor gave a short statement saying that he had no independent recollection of his involvement in the case. He declined to return from Australia where he was working to give evidence at trial and his statement was admitted into evidence under the Civil Evidence Act 1968. The statement made no reference to what he would have done if he had been summoned by the nurse. The trial judge made findings of fact as to what he would have done if he had been summoned. In making those findings, he drew an adverse inference against the doctor for his failure to attend and give evidence. He found against the Defendant. On appeal, the Court of Appeal held that the trial judge had been “entitled to treat [the doctor's] absence, in the face of a charge that his negligence had been causative of the catastrophe that befell [the plaintiff], as strengthening the case against him on that issue”. The circumstances of the present case are entirely different. The position of a doctor, not himself the Defendant but the person who is alleged to have negligently caused a catastrophic brain injury, is entirely different from the position of a peripheral witness who could corroborate the evidence of other witnesses in relation to a relatively minor detail in a much larger claim. In the present case, the Claimant was required to call sufficient evidence to prove her case and she was entitled to decide which witnesses she would call in order to do that. There was no obligation on her to call further

evidence. So far as the surveillance evidence was concerned, the Defendant was granted permission to rely upon it on 20 February 2024. The court gave the Claimant until 4pm on 23 February 2024 to file and serve witness statements of fact in response. The trial began on 1 March 2024. Looking at the chronology and the timescale for service of further evidence, it is not surprising that the Claimant did not call further evidence beyond providing updating statements from those witnesses who had already given witness statements and serving one additional statement from her other son Danny, who had been the sole carer on one of the days of the surveillance. In all the circumstances, I decline to draw an adverse inference.

117. In conclusion, the surveillance footage has been adduced for the purpose of undermining/disproving the Claimant's claim that she is attended by carers all the time. In my judgment it fails to do so, for the reasons set out above.

Expert evidence in relation to stoma and voice valve management

ENT: Homer/Heathcote

118. The order in which the evidence of the ENT experts emerged has some relevance to my assessment of it. They each produced an initial report, followed by a joint statement on 15 January 2024. Upon receipt of the updated clinical records, Ms Heathcote provided a further report dated 23 February 2024. Professor Homer did not produce a further report at this stage. The trial began on 1 March 2028. Ms Heathcote was present from 4 March 2024 onwards and Professor Homer was effectively on stand-by to attend when we reached the expert evidence. In fact, we did not reach the expert evidence until Friday 8 March 2024, which was a day when he could not attend. Ms Heathcote was present and was called and cross-examined. By the time the evidence resumed on 21 June 2024, Professor Homer had provided a further report and he and Ms Heathcote had prepared no fewer than 3 further joint statements dated 30 May 2024 (due to disagreement between the parties over the agenda) and Ms Heathcote had also prepared a joint statement with Ms Holmes dated 31 May 2024. On 21 June 2024 Professor Homer was called and Ms Heathcote was then recalled. Tracing the evolution of their opinions has formed part of my assessment of their evidence. For ease of consideration, I have subdivided their evidence into broad topics, although there is inevitably some overlap between topics.

ENT: Expertise

119. Professor Jarrod Homer has been a consultant in otolaryngology-head and neck surgery since 2002, initially at the Manchester Royal Infirmary and Christie Hospital and latterly at the Manchester Head and Neck Centre, Manchester University Foundation NHS Trust, the largest head and neck cancer centre in England. Since 2013 he has held an honorary chair in otolaryngology-head and neck surgery at the University of Manchester. His practice encompasses all of head and neck/thyroid cancer. He is currently the editor of the UK Multidisciplinary Guidelines for Head and Neck Cancer. He is also NHS England Getting It Right First Time (GIRFT) lead for ENT cancer. He has published over 100 research papers. He sees patients throughout their whole cancer journey. He runs a weekly clinic with SLTs in which they assess patients together. The further the patient is on their cancer journey, the more their care is carried out by SLTs, but he continues to be involved and that does not stop five years post operatively, because those who survive longer than five years and have significant issues may well

require some kind of medical follow-up. It was put to him in cross-examination that Ms Heathcote had greater experience of the rehabilitation of laryngectomy patients than he did. He disagreed, saying that most laryngectomy patients do not need to see a laryngologist and it was essentially head and neck surgeons like himself who provided the after-care from a medical point of view, alongside the SLTs.

120. Ms Kate Heathcote has been a consultant ENT Surgeon at Poole General Hospital since 2012. Having specialised in laryngology, in 2015 she established the Poole Centre for Airway Voice and Swallow. She runs a laryngology service for NHS patients. She is on the Council of the British Laryngological Society and she has lectured and published widely. She does not perform the laryngectomy surgery itself but is involved in the post-operative rehabilitation. She said that she sees patients in the head and neck clinic for five years post-laryngectomy, after which they are discharged, although she has patients who have been on her books for much longer. By way of example, she said that radiotherapy can cause difficulty swallowing and this can necessitate repeated balloon dilations. A lot of these patients also have voice valves and they would be seen at a joint clinic, with Ms Heathcote looking after their swallow and the SLT looking after their valve. However she accepted that it is the SLT, not her, who manages the valve and who assesses and arranges the patient's care at home. She also accepted that it is the SLT, not her, who is responsible for managing the patient's stoma, setting the patient up with the equipment they need to go home and setting up their care at home, although if the SLT is worried about something, for example if there is some granulation tissue that requires cauterisation, they would ask her to do it.

ENT: Causation

121. The Defendant's admission of liability included an admission that, absent the negligence, the Claimant would have had some radiotherapy, but no chemotherapy and no laryngectomy. In their joint statement dated 15 January 2024, as part of her answer to the question "please explain the nature of the Claimant's cancer and the treatment she has had to date", Ms Heathcote expressed the opinion that if the Claimant had only had radiotherapy, she would still have had a 53% chance of requiring laryngectomy within 5 years. This was an unexpected answer, partly because it did not arise out of the question that the experts had been asked, but mainly because it directly contradicted the Defendant's own admission of liability. Professor Homer responded, disagreeing with her and saying that the chance was less than 5%. They each relied on research studies in support of their contentions.
122. At trial on 21 June 2024, Professor Homer was cross-examined about his position. He explained the hierarchy of research papers. At the top of the hierarchy, he placed meta analysis of clinical trials, and just below that, the clinical trials themselves. They are the gold standard. The paper on which he relied was the report of The Radiation Therapy Oncology Group Trial 91-11 ('RT 91-11'), by Weber et al¹. He described it as a landmark clinical trial and a landmark paper for every head and neck surgeon. It considered the risk of laryngectomy in all patients, including a significant proportion with more advanced cancers than the Claimant and patients who received more aggressive treatment than the Claimant (the cohort included not just those who received

¹ Weber RS, Berkey BA, Forastiere A, Cooper J, Maor M, Goepfert H, et al. Outcome of salvage total laryngectomy following organ preservation therapy: the Radiation Therapy Oncology Group trial 91-11. Arch Otolaryngol Head Neck Surg. 2003;129(1):44-9

radiotherapy but also those who received chemo-radiotherapy and those who received induction chemotherapy, as especially toxic treatment that is no longer used). It found that the percentage of patients requiring laryngectomy following chemo and radiotherapy was less than 5% and for those patients who only had radiotherapy, the percentage was around 2%. He demonstrated, by reference to the paper, where these figures were to be found. He said that we are not just dependent on the findings in the clinical trial. We can apply a real world sense check to these findings and we can ask the question, do we expect about 2% of patients who have radiotherapy for laryngeal cancer to require laryngectomy and he said yes, that makes complete sense and accorded with his extensive clinical experience. He said that, by contrast, if any head and neck cancer unit was reporting laryngectomy rates of 50% in patients who had been treated only with radiotherapy, then this would be so far outside normal practice that the unit would be shut down. He said that he struggled to find a word strong enough to reflect his assertion and opinion on this point, although he did later describe the Defendant's proposition as "outlandish". By contrast, the paper relied upon by Ms Heathcote was much further down the hierarchy of research papers. It was a retrospective cohort study², which he described as low level evidence. He said that one of the papers was wrong and it was not the clinical trial.

123. I observe that there is strong support for Professor Homer's position in the report of Professor Symonds, clinical oncologist. He considered what would have happened if the Claimant had been referred on an urgent basis on 18 January 2016, i.e. if there had been no negligence. His opinion was that she would have had radiotherapy alone which would have cured her of cancer. In his opinion "serious permanent damage following radiotherapy is rare and the incidence of laryngeal necrosis is less than 1%", and "on the balance of probabilities she would have had totally normal speech and no disability".
124. When Ms Heathcote later gave evidence, she did not respond in evidence-in-chief to Professor Homer's evidence about the risk of laryngectomy in patients who have only had radiotherapy and she was not cross-examined about it.
125. I prefer and accept Professor Homer's evidence on this issue. He gave, in my judgement, a complete answer and an entirely persuasive one. I am somewhat surprised that Ms Heathcote raised the issue in the first place, given Defendant's own admission, the results of clinical trial RT91-11, real world experience and the evidence of Professor Symonds.

ENT: Stoma/airway management

126. In their joint statement dated 15 January 2024, they agreed that post-laryngectomy the stoma needed to be kept clean, home suction was almost always needed and often additional humidification. Failure to do these things meant the stoma could get infected and crusty and can cause airway obstruction and predispose to respiratory tract infection. Therefore the airway was vulnerable unless properly looked after. Daily care required frequent cleaning of the stoma and/or tube, which requires some co-ordination using a mirror and some degree of manual dexterity. The additional secretions, mucus and coughing associated with COPD will add to the frequency of needing suction and

² Anschuetz L, Shelan M, Dematté M, Schubert AD, Giger R, Elicin O. Long-term functional outcome after laryngeal cancer treatment. *Radiat Oncol.* 2019;14(1):101

needing to deal with and prevent crusting. The loss of natural humidification requires mitigation. Regular suction may be required and should always be available. Cough effort can also be reduced or less effective. The harvest of the Claimant's pectoralis major muscle will have contributed to shoulder and neck stiffness.

127. Professor Homer expressed the view that some patients, like the Claimant, have a degree of neck swelling/thickness (made worse by radiotherapy and surgery), which can make access to the stoma more difficult and which was demonstrated by the photographs within Helen Howison's report. He also expressed the view that difficulties with dexterity and vision can compromise things further. He said that the assessment of these problems was not something that ENT surgeons dealt with clinically and it was a matter for specialised nurses and allied health professionals.
128. Ms Heathcote added that in her opinion, although the Claimant has some restriction of movement of her right shoulder, she does not have a manual dexterity problem as demonstrated by her ability to make jewellery. Her vision problems are age related long-sightedness as experienced by the majority of laryngectomees who, despite this, manage to self-suction.
129. Breaking off from this consideration of the ENT evidence for a moment, the question of whether the Claimant did or did not make jewellery was disputed. It seemed, at least at one point during the trial, that it might be of some significance due to Ms Heathcote's opinion set out above. In fact, as her evidence developed over the course of two visits to the witness box and various joint statements, she came to accept that the Claimant required care in respect of both her voice valve and her stoma. That being so, it seems to me that the issue of jewellery making was probably redundant. Nevertheless, it was an issue that exercised Ms Palmer and it continued to feature in the Defendant's closing submissions and so for completeness I deal with it here.
 - i) The Claimant had told a number of the experts that she made jewellery and in her Facebook posts, she had posted pictures of jewellery which she said she had made. However when this was put to her in cross-examination, she replied that she was not making jewellery but marketing it for her friends and carers, Janette and Annie, who were the people who actually made it. She helped market it and put it on Facebook to sell it. The proceeds went to a youth charity that the Claimant had been a trustee of for many years and of which Janette was the CEO. She said that she was not going to put on Facebook that her carers made the jewellery, that was not the sort of thing you said on Facebook. She said that she ordered the beads and she marketed it. She said that if she had made it, she would say so because it was not any problem to her to say that she made jewellery. It was put to her that she was saying she had problems with suctioning and using forceps because of her manual dexterity and making jewellery requires manual dexterity, the implication being that if she could make jewellery, she could care for her stoma. She disagreed that they were comparable, but in any event she maintained that she did not make jewellery.
 - ii) In isolation, the Claimant's evidence that she did not make jewellery seemed to me to be credible and her denials were convincing. If she had been making jewellery, there seemed no good reason to deny it. The point that was being made – that if she could make jewellery she could manage her stoma and voice valve - did not seem to me to be particularly persuasive, partly because working

with your hands in front of you is very different from trying to manipulate equipment in reverse within your own stoma, but mainly because the more important point about the Claimant's stoma and valve care is her inability to visualise within her stoma. By denying that she made jewellery, she placed herself in conflict with the social media posts and what she had said to the experts, with the obvious risk to her credibility. If she had been making jewellery, it would have been much easier just to say so. Yet she denied it and that put her in conflict with other evidence. I therefore asked both Anna Crowley and Dayne Cullen about it. I was quite sure that if she had been making jewellery, they would have been aware of her doing so. Neither had been cross-examined about it by the Defendant, nor was either of them asked about it when there was an opportunity to do so after my questions. I asked Anna Crowley if she had ever seen the Claimant make jewellery and she said no. I asked Dayne Cullen the same question and he said that he had never seen his mother make jewellery. He said that she could be what he described as a helicopter jewellery maker, in that she knows what would look good, but she does not make jewellery. He said that she could not even thread a needle and that he had had to sew his own school trousers for years. I found each of them to be an otherwise honest witness and I found their evidence on this issue to be convincing. It tipped the scales in favour of the Claimant's account on the issue of making jewellery.

130. Returning to the ENT evidence in relation to stoma management, following the joint statement Professor Homer produced a further report dated March 2024. He affirmed the use of forceps to stop harder secretions from blocking the Claimants stoma. He said that her cough, although described as "strong", is not strong enough to clear her lungs. This is because she has no means of attaining the expiratory resistance needed to generate enough intra-thoracic pressure to clear her airway.
131. Professor Homer gave evidence at trial on 21 June 2024. He reiterated that in relation to stoma management and voice valve management, he would defer to the SLTs. He was, nevertheless, asked for his opinion on aspects of both. So far as stoma management was concerned, he said that secretions could block the Claimant's stoma so as to pose an immediate risk to her. He said that secretions could impair her airway. He said that "a great big thick globule would impair the airway, particularly if it was hard and crusty", but it could do so "even if it was soft and very mucoid and therefore sticky and tenacious". It was put to him that Ms Heathcote had said that the secretions are not going to occlude the Claimant's airway and he said that it can be blocked through secretions, amongst other things. He strongly disagreed with the suggestion that her airway was somehow better after her laryngectomy. He said that the secretions can block the tube very very quickly. It does not take much for that to happen. A patient can therefore go from having no problems and then something happens such as forgetting to suction, or suctioning badly, or some other change in environment, or an exacerbation of COPD etc, and then quite quickly there can be mucus that comes up from the chest and blocks the airway. It is rare that it is life-threatening but it can happen and it is unpredictable. He said that they sometimes see it in hospitalised patients. It was put to him that with coughing, suction and the use of a nebuliser, you are not going to get into such a situation and he replied that the risk is highly mitigated by such measures but the risk is certainly not zero and it can happen. He said that it is highly unlikely to happen with correct and optimal management.

132. At trial on 8 March 2024 Ms Heathcote agreed that due to the loss of the upper airway following laryngectomy, there is less humidification of the airway and secretions are prone to becoming thicker. In addition, the Claimant has COPD which again produces more viscous secretions that are harder to clear. She agreed that the secretions would change slightly with the seasons and also with infections. These thicker, more viscous secretions are consistent with the photographs produced by the Claimant showing secretions that had been removed from her airway. She said that more frequent use of an HME and nebuliser would make the Claimant's secretions more manageable and she advised using the nebuliser twice a day. But she accepted that COPD and infections would make secretion removal an ongoing issue throughout the day. She accepted that the sort of episodes that the Claimant experienced during the trial, where she started to cough and she had to clear her stoma (with the assistance of her carer), were absolutely normal and could be expected during the day. If it was not possible to clear her airway in this way, then the nebuliser would be required. Miss Heathcote said that suction could be used, although the secretions may be too big for the pipette, in which case forceps can be used to remove them. She agreed that using forceps was part of routine care. She agreed that in order to use forceps, you have to be able to see where the valve is and you also have to be able to see where the secretions are. She said that it was reasonable to use forceps to go down about an inch or so into the stoma, but she would not advocate going any further down into the stoma with forceps. She agreed that the depth indicated by Anna Crowley was reasonable.
133. As to the risks associated with secretions, she said that the Claimant "is not going to acutely occlude her airway and drop dead". She accepted that it is frightening, but she said that patients get used to it. Later in her evidence she said that if the Claimant did not have help, her impression was that she would probably manage. Later again she said that airway obstruction was the critical thing, whether she could obstruct her airway and die. And she said that that was a fear, but not a reality. She repeatedly returned to the theme of safety.
134. She disagreed with the SLTs opinion that it is not anticipated that the Claimant will ever attain competence in caring for her stoma and/or voice prosthesis independently, even with further intensive training. Ms Heathcote said that she thought that with training, the Claimant could manage her stoma care, although she would need help managing her voice prosthesis.
135. During the period when the trial was adjourned part-heard, Ms Heathcote and Professor Homer prepared further joint statements dated 30 May 2024. In answer to the question "the SLT experts say that Ms Cullen requires help from carers to manage her stoma care: do you agree?", they replied "Both experts agree".
136. Ms Heathcote and Ms Holmes then prepared a joint statement dated 31 May 2024. In that joint statement Ms Heathcote expressed the opinion that she cannot be sure what the Claimant can and cannot see within her stoma but because the Claimant can see the entrance, she will also be able to see inside. Ms Heathcote was of the opinion that the Claimant could use suction at the entrance to her stoma and into her stoma, and she could use forceps effectively to clean her stoma. However neither suction nor forceps should be used deep into the trachea.
137. When Ms Heathcote gave evidence at trial on 21 June 2024, she was asked about her opinion in the joint statement with Professor Homer dated 30 May 2024, that the

Claimant requires help from carers to manage her stoma care. She confirmed that that was her opinion.

ENT: Voice valve management

138. In their joint statement dated 15 January 2024 they were agreed that the Claimant's voice valve needed to be kept clean, otherwise it would fail, preventing speech and leading to aspiration if throat contents leak into the airway. They were agreed that the Claimant's stoma is quite small and her voice valve is situated at the back of the stoma. Hence all the challenges applicable to stoma management apply, but "with a significantly greater degree of magnitude". Professor Homer added that for such a stoma, cleaning the valve with a brush is difficult and may need doing several times a day. It was not until after this joint statement, that the most recent clinical records were received containing the description of the Claimant as a 'self-changer', and it was later still that the clarification as to the meaning of 'self-changer' was received.
139. Professor Homer did not provide a further report when the 'self-changer' issue arose, nor when it was clarified. He did prepare a further report dated March 2024, during the period when the trial was adjourned part-heard. He noted the problems with her voice valve and commented that stiffness in the Claimant's reconstructed pharynx may be a cause of valve failure. He described the problems associated with a dislodged valve, which, if it falls into the trachea, would inevitably require emergency admission to hospital for bronchoscopy to retrieve the valve. He described the problem of leaks around a valve and how they may be addressed by a valve change, but may require emergency admission. He said that these problems are an occasional but constant threat and what tends to disturb patients most is that they are entirely unpredictable.
140. Professor Homer gave evidence when the trial resumed on 21 June 2024. He confirmed his reports. He also said that if a valve was dislodged and fell anteriorly into the lungs, that would be highly distressing for the Claimant and she would need a carer to take her to hospital. It was put to him that if the Claimant's voice prosthesis leaks, "all she has to do is go to hospital and get her valve replaced". Professor Homer took exception to the phrase "all she has to do". He considered it an inaccurate and unfair way to describe a situation in which the Claimant would have saliva from her throat trickling through into her lungs, giving rise to a potential chest infection and issues with airway safety.
141. Ms Heathcote, following the joint statement and following receipt of the up-dated clinical records with their references to "self-changing", produced a short report dated 23 February 2024 expressing the view that the Claimant was already able to perform independent voice prosthesis care and she must therefore also be able to perform independent stoma care.
142. Ms Heathcote was present in court when the Claimant gave evidence at trial. Ms Heathcote was called to give evidence on 8 March 2024. She confirmed her reports and was then cross-examined. More or less the first thing she was asked in cross-examination was whether her opinion had changed following clarification of what was meant by "self-changing" in the clinical records. She said that her opinion had changed as to whether the Claimant needs someone else to assist her with changing her voice valve and she agreed that the Claimant should not change her voice valve by herself and that she needed someone else to assist her in changing it. She was asked why she

had not put this change of opinion in writing (or notified the court of it in any other way). She said that the first time she saw Lindsay Lovell's witness statement was on Monday 4 March 2024, which was the second day of trial. She was in court, following proceedings using the electronic trial bundle that she had been provided with, and she came across the statements in the trial bundle. She said that she was not aware of her obligation to the court to put her change of opinion in writing and "[she] presumed that [she] was going to give evidence at some point and these things would come up". This was disappointing for a number of reasons. First, it was a breach of the Practice Direction to CPR Part 35, which provides at paragraph 2.5: "If, after producing a report, an expert's view changes on any material matter, such change of view should be communicated to all the parties without delay, and when appropriate to the court." Second, at a pre-trial hearing on Wednesday 28 February 2024 I had specifically asked why the defence experts, who had been quick to seize upon the term "self-changer" in the clinical records, had not provided up-dating reports in the light of Lindsay Lovell's evidence that the term did not in fact mean that the Claimant was able to change her voice valve on her own. I was reassured that the new evidence had been sent to the experts. Third, on the first day of trial, Friday 1 March 2024, the issue arose again, and I was told that there had been insufficient time to deal with it yet, but the experts would be at court on Monday and their views would be checked. It is disappointing therefore to learn that Ms Heathcote only became aware of Lindsay Lovell's evidence by looking through the trial bundle on Monday 4 March 2024 and that no notice of her revised opinion was received prior to her giving evidence on Friday 8 March 2024.

143. In any event, in relation to cleaning the Claimant's voice prosthesis, she agreed that it needed to be cleaned because you can get food sticking in it on one side, mucus on the other side, and you can also have issues with fungal infections. She agreed that it should be cleaned "under vision" because of the risk of dislodging the valve and it dropping down into the trachea. However she said that SLTs are better able to advise in relation to cleaning the valve.
144. In relation to turnover of valves, she said that part of the reason that the Claimant gets through so many valves is the pressure that she places on the valve by her speaking voice. She said that this is down to her personality and how much she uses her voice and how she uses her voice, which is something that is quite hard to modify.
145. In relation to emergency measures when a valve leaks or is dislodged, she said that a patient could drink thickeners, or insert a stoma gastric tube or a plug into the puncture. She observed that a stoma gastric tube is easier to insert than a new valve, it being flexible and "they sort of find their way" into the puncture.
146. In relation to valve changes, she said that the position of the Claimant's voice prosthesis within her stoma was not optimal but it could be worse. She thought it was quite easy to see but she accepted that it might be difficult to insert the valve. She had not changed the Claimant's valve herself and from looking at the Claimant's clinical notes, it appeared to be difficult to change. She said it is a very individual thing and long-term patients know more about their condition than anyone else. Pausing there, it seems to me that this reasoning would apply equally to a regular carer such as a patient's partner or in the Claimant's case, to Anna Crowley and Dayne Cullen, and their evidence of the difficulties associated with the Claimant's valve care should be weighted accordingly. Ms Heathcote agreed with the SLTs that the Claimant remains at least partially dependent upon her carers to undertake tasks such as cleaning the valve,

changing the valve, performing leak tests and undertaking emergency measures when needed such as insertion of a stoma-gastric tube into her puncture if the voice prosthesis became dislodged. She thought that the Claimant would continue to need support in relation to her voice prosthesis. She agreed that the Claimant is “not safe to undertake changing a prosthesis by herself.”

147. During the period when the trial was adjourned part-heard, Ms Heathcote and Ms Holmes prepared a joint statement dated 31 May 2024. In that joint statement, amongst other opinions, Ms Heathcote expressed the opinion that because the Claimant can see the entrance of her stoma, “therefore she will be able to see inside”. She asserted that “independent valve changing at home has been occurring on a regular basis”. And she was of the opinion that the Claimant does use the brush (to clean her valve) and forceps (for stoma cleaning) effectively. She was of the opinion that the Claimant was a home valve changer with, and at times without, assistance.
148. On 21 June 2024 Ms Heathcote was challenged about these assertions and she said that she thought that that was what the Claimant had said in evidence. She was then taken through various parts of the transcript of the Claimant’s evidence and she accepted that her assertion in the joint statement was wrong and the Claimant had not said that she was changing her valve at home without assistance. She was taken to the transcript of her own evidence given on 8 March 2024 and she was asked “looking at the evidence in total, do you agree that your recollection is incorrect and [the Claimant] is not able to change her valve?”, to which she answered “yes”. She also said that she was unclear on whether the Claimant could see the valve to put a brush into it to clean it, but she said that the Claimant should not necessarily be doing that, particularly if she had a carer to hand.

ENT: Prognosis and care needs

149. In their joint statement dated 15 January 2024, they agreed that they did not expect any material changes in the Claimant’s present condition. They agreed that the assessment of care needs was not something that ENT surgeons deal with clinically and they deferred to other experts.
150. They disagreed on the proportion of tracheostomy patients who have 24-hour care. Ms Heathcote said that she was not aware of any patients in her region requiring paid care 24/7. Professor Homer said that he could not give a percentage figure but it was not infrequent in his experience of over 20 years in Greater Manchester. He said that many patients in effect have it through their partners and family who live at home with them (his evidence on this point was consistent with that of the SLTs).
151. Professor Homer then produced a further report dated March 2024. He said that having met the Claimant and from considering the records, he considered her to have been extremely well motivated to become as independent as possible and he did not think there was scope to train her to become more independently capable of seeing to her own needs. As she gets older, her needs will increase rather than diminish. He said that the safety issues associated with her valve and tracheostomy tube are ever present. He described having a laryngectomy as a life changing event and one which constitutes a major disability. In addition to the physical changes, it has a significant effect on image and self-confidence. He said that the pressure on head and neck services local to the Claimant is such that it is unrealistic to think that she could simply be seen rapidly

within the NHS should problems arise. He reaffirmed that the assessment of the Claimant's care needs was for specialised nurses and allied health professionals, particularly SLTs, and that he and Ms Heathcote had deferred to their opinion. He agreed with the contents of the updated joint statements of the SLT experts.

152. When Professor Homer gave evidence at trial on 21 June 2024, he reiterated that in relation to stoma management and voice valve management, he would defer to the SLTs.
153. When Ms Heathcote gave evidence at trial on 8 March 2024, she started by reiterating that she did not "have a single laryngectomy patient who has 24-hour care. That's the bottom line." Under cross-examination she accepted that it was perfectly reasonable to have someone else help you with your valve, but most often that person would be the patient's partner "who doesn't come on a salary". She also suggested that when there was a problem with the valve, the Claimant did not have to change her valve, she could just not use her voice so much and use thickener (something the Claimant particularly dislikes and which Ms Heathcote herself described as "very unpleasant") and attend hospital to have it dealt with by the SLTs. She observed that the reason the Claimant and her carers have changed the Claimant's valve is because she is desperate to get on with her life and when she has not been able to see a SLT on the day and has been told to come back the next day, she and her carers have changed the valve at home. It was put to her that that is what many patients do, with the support of their family and friends, and Ms Heathcote said that the difference was that they are not paid carers. She seemed to be implying that in the absence of a partner who was prepared to provide this care for free, the Claimant ought to fall back on not speaking, using thickeners and waiting for an appointment. Later in cross-examination the SLTs' agreed joint statement that "up to 50% of people post-laryngectomy are not fully independent in the care of their stoma and/or voice prosthesis. Most often they have a partner or other family member who is able to assist with care tasks at home" was put to her and she agreed with it. Later still she said that "it's about optimising life and if you took away a lot of that care, she would still live, but she would not live the life that she wants, and that is the critical thing, isn't it? If she wants to live a life of travel, and all the other things that she does, then she is going to need more, you know more intense support, than if she is just at home with a hospital round the corner." She observed that the Claimant had done exceptionally well and had achieved an awful lot with the support of her family.
154. When she gave evidence again at trial on 21 June 2024, she repeated that she did not have any patients that have 24 hour paid care, but she went on to accept that the majority of patients will have someone living with them. She also said, in relation to emergencies, it was those patients who did not have someone living with them, who were more likely to end up in hospital. Right at the end of cross-examination, she was taken to her and Professor Homer's first joint statement in which they were asked about the claim for 24 hour care. Her reply had been that she would "defer to the relevant therapist (physio, OT and SLT) who manage these issues". She was asked if that remained her view and she said yes.

ENT: Conclusions

155. In conclusion, I accept the evidence of Professor Homer. To the extent that there was a difference of opinion between Professor Homer and Ms Heathcote, I prefer and accept the evidence of Professor Homer. He had greater experience, he was demonstrably

more expert and more balanced on the issue of causation, his evidence was internally consistent and externally consistent with the evidence of the SLTs. All that said, by the end of Ms Heathcote's evidence, there was in fact very little between them.

SLT: Holmes/Williams

SLT: Expertise

156. Ms Samantha Holmes is the clinical lead SLT for head and neck cancer at Oxford University Hospitals. She has specialised solely in head and neck cancer since 2013, head and neck cancer pathway, from the point of diagnosis to longer-term survivorship. In her capacity as an NHS specialist SLT, she saw the Claimant twice during her admission to UCLH following her laryngectomy surgery, but had no contact with the Claimant following her discharge in August 2017 until instructed as an expert witness in this case. There was no challenge to her independence or her expertise.
157. Mr Mark Williams has been in practice for nearly 40 years in SLT and assistive technology, working in both education and healthcare settings. Prior to 1990, he was employed at educational establishments catering for the needs of children and young adults with cerebral palsy, developing and managing programs aimed at the development of communication skills. Until January 2015, he was head of department at the Assistive Communication Service, an NHS service providing assessment, information and training in relation to assistive communication technology. He currently practices independently and is a medicolegal expert for SLT and for assistive technology. He accepts instructions on behalf both Claimant and Defendant.
158. So far as the relative expertise of different specialties is concerned, Ms Holmes and Mr Williams were in agreement and stated that their expertise differs from that of Ms Heathcote in relation to laryngectomy. They stated that "from the point of diagnosis, the patient is under both SLT and their Head and Neck ENT consultant. Once a patient is five years post-diagnosis, they are usually discharged from ENT consultant follow-up entirely, and then solely managed by the SLT team. A laryngectomy patient would be brought to an ENT consultant clinic - most often a head and neck ENT consultant but, in some instances, a laryngologist - purely for interventional input that was outside of the SLT remit to provide. For example, if a patient required a stomoplasty (surgery to enlarge the stoma) or the injection of some filler to prevent peripheral leak, or a biopsy of an area of concern in tissue, the SLT would request a clinical review and the patient would be seen in an ENT clinic jointly by the ENT and the SLT professionals for the intervention to take place. However, outside of this, the patient remains under the care of the SLT for life for ongoing rehabilitation and management. As such, issues pertaining to care of the stoma and valve, competency and training, voice prosthesis management and swallowing management are primarily under the remit of the SLT." I observe that this is entirely consistent with the evidence of Professor Homer.
159. It is conspicuous that SLT is the expert discipline to which other experts have deferred (correctly in my view) when it comes to stoma and voice prosthesis management. It is also conspicuous that the SLT experts in this case are in complete agreement. I accept their evidence.
160. Since Ms Holmes and Mr Williams were in complete agreement, there is perhaps no need for me to assess them further as witnesses. However Ms Holmes was cross-

examined with some vigour and her conclusions challenged, notwithstanding Mr Williams' agreement with her. I therefore record my views. I found her to be a thoroughly impressive witness, expert in her field and balanced in her approach. I accept her evidence. Mr Williams was also called. He and Ms Holmes had been agreed in their joint statements, which he confirmed. He had now heard the ENT evidence and he had heard Ms Holmes being cross-examined. He was asked if there was anything in his evidence (i.e. his agreement with Ms Holmes) that he wished to change and he confirmed that there was not. In these circumstances he was not cross-examined. I accept his evidence.

161. As with the ENT evidence, I shall summarise their evidence by topic.

SLT: Stoma/airway management

162. In relation to stoma/airway management generally, they were agreed on the following:-

- i) Although most people with laryngectomy are able to manage without suction as they progress through their rehabilitation post-surgery, some people with laryngectomy continue to require suctioning of secretions years after their operation. This is more commonly seen in people who have co-morbidities such as COPD as they often have higher secretion loads to manage.
- ii) Nebulising is not always sufficient to completely loosen the secretions to the point where they can be suctioned from the entrance of the stoma.
- iii) Suctioning can be more difficult where the stoma is small. When a voice prosthesis is in situ, there must be a high degree of caution used while suctioning so that the voice prosthesis is not dislodged by the suction pipette. This requires adequate visualisation of the voice prosthesis, alongside dexterity to manipulate the pipette. Deep suction requires a view into the stoma to avoid dislodging the valve or causing suction trauma to the tracheal tissues.
- iv) It is common practice for SLTs to provide metal forceps to people with laryngectomy, for the patient or a carer to use to remove secretions from the stoma. Tweezers are less suitable as the ones that are routinely provided are wide and will obstruct the view into the stoma significantly.

SLT: Voice valve management

163. In relation to voice prosthesis management generally, they were agreed on the following:-

- i) The voice prosthesis must be cleaned 1-3 times daily as a minimum, especially after mealtimes as often the end of the voice prosthesis that sits in the food-pipe can become blocked from food and drink passing over it. The voice prosthesis also needs cleaning ad-hoc throughout the day as it can become blocked at any time, by saliva, by reflux gastric contents or by chest secretions. Blockages can result in a partial or complete loss of voice and can also result in leakage of saliva/food/fluid through the voice prosthesis and into the lungs, which poses a risk of respiratory complications such as a chest infection. Cleaning a voice prosthesis requires the insertion of a wire/bristled brush into the barrel of the

voice prosthesis, which is only a few millimetres in diameter and can be obscured by secretions. It is imperative to be able to visualise the valve to be able to clean it.

- ii) When the voice prosthesis begins to leak frequently, it is a sign that it requires replacing with a new voice prosthesis. This can be done by the individual themselves in certain cases; by trained family members or carers, or hospital-based SLT services. Not every option is appropriate for all people with laryngectomy, and can depend upon many factors such as the type of voice prosthesis that is in place, the complexity of changing the prosthesis, the size of the stoma and individual factors such as vision and dexterity.

164. In relation to the Claimant's voice prosthesis in particular, they were agreed that there are features of the Claimant's altered anatomy and personality which are relevant to the longevity of her voice prostheses. They are:-

- i) The Claimant's puncture/voice prosthesis sits in tissue over which the peristaltic wave passes. This is most likely due to incomplete myotomy. The result is that the voice prosthesis is continually squeezed during swallowing, which contributes to leakage around the prosthesis.
- ii) The Claimant's puncture/voice prosthesis sits in irradiated tissue, which is friable and less able to sit snugly around the voice prosthesis, making it prone to peripheral leak.
- iii) The Claimant puts a high vocal demand on her voice prosthesis.

SLT: Care needs of laryngectomy patients generally

165. In relation to the proportion of patients who require on-going care:-

- i) For a person with a laryngectomy, who also has undergone surgical voice restoration, either they themselves or a carer must be competent in caring for both the stoma and voice prosthesis in order for them to be able to live independently.
- ii) From their clinical experience, the SLT experts agree that up to 50% of people post-laryngectomy are not fully independent in the care of their stoma and/or voice prosthesis, but most often they have a partner or other family member who is able to assist with care tasks at home.
- iii) The proportion of people who require the provision of 24-hour care from external services, i.e. private or care home facilities, would be around 10%. This figure would be higher but for the fact that the anticipation of someone needing 24-hour care is often a reason why surgery would not be offered at all, or would be offered without surgical voice restoration.

SLT: Claimant's care needs

166. So far as their opinions on the Claimant's care needs are concerned:-

- i) They are in agreement that the Claimant's care needs are unpredictable and that, consistent with her high secretion load, she requires frequent cleaning of her stoma and voice prosthesis. They are agreed that the urgency of these care tasks can vary from routine to emergency without any predictability.
- ii) They respect the Claimant's account of what she can and cannot see of her stoma and the voice prosthesis. It seems to me that, inferentially, this must mean that her evidence on this point is not inconsistent with their experience as SLTs.
- iii) They are agreed that the position of the Claimant's voice prosthesis is such that it is easier for a third party to see and access it, than it is for the Claimant herself. They are in agreement with the comments to this effect contained within the clinical records (see SLT records for 22 July 2022).
- iv) They are agreed that the Claimant is unable to visualise the voice prosthesis in the stoma to any functional benefit. Even a partial or intermittent view is not sufficient for the purposes of undertaking care tasks safely. The factors that restrict the Claimant's ability to visualise her voice prosthesis include the sub optimal size of her stoma, the position of the voice prosthesis within the stoma, the Claimant's visual acuity and the fact that the introduction of any tools into the stoma takes up most of the space within the stoma and obscures the view.
- v) So far as cleaning her voice prosthesis is concerned, they are agreed that she is unsafe to perform this task independently. In order to clean it, it is necessary to be able to see it. Although she can attempt to get the brush into the barrel of her valve, she is unable to do so accurately, risking trauma to the tissues of her trachea and dislodgement of the voice prosthesis itself.
- vi) So far as changing her voice prosthesis is concerned, they are agreed that the Claimant has a higher than usual turnover of voice prostheses due to the factors set out above. They are further agreed that she is not able to safely or independently change her voice prosthesis without the assistance of her carers. Safe independence in care would require the Claimant to demonstrate an ability to safely and competently perform all procedures associated with stoma and valve care to the satisfaction of her treating SLT team. This is usually done through a competency-based document, the exact nature of which differs from team to team. The Claimant has not been able to demonstrate such competency and is therefore considered unsafe to care for her own stoma and valve by her treating SLT team and also by both SLT experts.
- vii) So far as stoma and airway management is concerned, they are agreed that the Claimant can see the entrance to her stoma using a mirror but any view beyond the entrance is extremely limited. They are agreed that the Claimant is able to safely remove secretions from the entrance to her stoma using the suction pipette and using forceps. However, they are agreed that she would be unsafe to attempt to remove secretions from deep within her stoma due to lack of visualisation, the risk of trauma to the tracheal tissues and the risk of dislodging the voice prosthesis. They are agreed that, with appropriate training, these tasks can be performed safely by carers as they have a better view into the stoma and can ensure that they are not dislodging the valve or causing suction trauma to the tracheal tissues.

- viii) They are agreed that the Claimant is incompetent in caring for her laryngectomy and stoma independently.
- ix) They are agreed that she requires 24-hour care to meet these needs.

Care: Howison/Palmer

167. Mrs Helen Howison has been a registered nurse since 2000. From 2000 to 2004, she worked in the cardiothoracic oncology wing at the University Hospital of Wales. From 2004 to 2006 she worked as a ward sister at Velindre Hospital, a specialist cancer centre. From 2006 until 2021, she was a lung cancer and mesothelioma specialist and was the lead nurse at the Aneurin Bevan University Health Board, another NHS hospital. In this role, she and her colleagues bridged the gap between the secondary care acute setting and the community. She worked in an outpatient setting, and also visited patients at home, facilitating their care between oncology hospitals, community nurses, palliative care and the outpatient setting. From April 2021 to May 2022, she was a cancer information nurse specialist with Macmillan, giving advice and support to people living with cancer. Alongside this work, from October 2019 until 2021, she had her own independent practice as an expert witness. In 2021, she joined Charlotte Wells & Co and since May 2022, her work has been exclusively that of an expert witness. She prepares between 25 and 30 reports each year. To date, although available to be instructed by both Claimants and Defendants, her instructions have been exclusively from Claimants. She has not constructed, designed or managed a care package in the community.
168. Ms Marie Palmer is an occupational therapist. She qualified in 1979. She has worked in both the NHS and community settings, with children and adults. Her CV includes a long list of categories of people and types of condition with which she has worked. Although the list does include cancer and respiratory conditions, it is clear that her practice is very broad-based. However, she does have experience of developing care packages. She has also worked as a case manager with Harrison Associates and worked with clients who are under the Court of Protection. She has also worked as an NHS manager. She has been an expert witness since 2003 and is currently in independent practice. Her instructions are a mix of Claimant (40%), Defendant (58%) and joint (2%) instructions.
169. In short, Mrs Howison has much more experience than Ms Palmer in cancer care generally and lung cancer and mesothelioma in particular. Ms Palmer has much more experience than Mrs Howison in putting together and managing care packages in the community. Neither gave evidence of having put together a care package for a patient with similar needs to the Claimant.
170. In terms of their approach to the facts, Mrs Howison has essentially proceeded on the basis of what she has been told by the Claimant and on the basis of the preponderance of ENT and SLT expert opinion. By contrast, Ms Palmer has taken every opportunity to comment adversely on the Claimant's evidence. She has also shown a marked reluctance to consider the whole of the ENT and SLT evidence, fixing on Ms Heathcote's initial scepticism to the exclusion of the evidence of Professor Homer, Ms Heathcote's later evidence and in particular the evidence of Ms Holmes and Mr Williams. I have not found this to be a helpful or balanced approach. All that said, the short point is that the facts are for me to determine and I have not found the expert care

evidence to be of assistance in that task. I shall return to the care evidence when I turn to quantification.

Findings of fact in relation to management of the Claimant's stoma and voice valve

171. I have already set out my impression of the Claimant when she gave her evidence. She impressed me as an honest witness. Since the evidence closed I have spent a great deal of time with the transcript and with the trial bundles, going back over the evidence and considering the Defendant's various submissions. I have included my observations on the evidence elsewhere in this judgment and it is not necessary to repeat them here. But put simply, the Claimant's account of her condition, the difficulties she faces in the management of her stoma/airway and voice valve and the assistance that she needs and has received, is strongly supported by the lay witness evidence, the factual evidence of experts who have seen her encounter these difficulties during assessments and the opinion evidence of those experts with the greatest experience and expertise in this field, namely Professor Homer, Ms Holmes and Mr Williams. I have considered and rejected the Defendant's allegations of fundamental dishonesty for the reasons given later in this judgment. In all the circumstances, my overall assessment of the Claimant is that she was an honest witness and I accept her evidence.
172. My factual findings in relation to the management of the Claimant's stoma/airway and voice valve are as follows.
173. The Claimant's stoma is small in size. The photographs that accompany the reports of Professor Homer and Mrs Howison accurately show the stoma.
174. Her voice prosthesis is situated deep/low within the stoma. Due to the angle of the posterior wall, the 'face' of the prosthesis is generally past the vertical, looking downwards into the airway. There is day to day variability in the position of the voice prosthesis, depending on neck position and muscle tension.
175. Access to and visibility within the Claimant's stoma is made more difficult by a degree of neck swelling/thickness consequent upon radiotherapy and surgery.
176. The size of her stoma and the position of the valve make stoma and valve management much more difficult. All the normal challenges that apply to stoma and valve management apply in the Claimant's case, but with a significantly greater degree of magnitude.
177. In order for someone to perform any form of stoma or voice prosthesis management within the stoma, the Claimant has to tilt her head backwards. In this position, it becomes very difficult for her to see into her stoma. She is sometimes able to see her voice prosthesis, depending on its position, but she cannot do so reliably. She cannot see down into her stoma below the level of the entrance.
178. For a carer to be able to see her voice valve, or to look down into her stoma, it is necessary to come up close to the Claimant and, using a handheld torch, to look down into her stoma at a particular angle.

179. These difficulties present themselves to the Claimant's carers and to the specialist SLTs who have looked after her at the Royal London Hospital. The note of 22 July 2022 is an accurate reflection of these difficulties.
180. The Claimant is now 67 years old. She is long-sighted. She is not particularly dextrous. These factors contribute to her difficulties with stoma/airway and valve management.

Stoma/airway management

181. The Claimant has a high secretion load as a result of her laryngectomy and her COPD.
182. She coughs frequently. Her cough is not as strong as it would have been absent the laryngectomy, due to her altered anatomy. She is able to bring some of her secretions up to the entrance of her stoma where she can wipe them away with a tissue without having to visualise her stoma at all. She can visualise the entrance to her stoma sufficiently well to be able to use suction and forceps at the entrance to her stoma or just inside, although this is not risk-free.
183. However she frequently produces secretions that she cannot cough to the entrance of her stoma and cannot remove herself. These become stuck below the level of her voice prosthesis. They cause her significant respiratory distress and feelings of panic and they need to be removed quickly. In addition, there is a small risk that they will occlude her airway altogether, which would be life-threatening. In order to ensure that this risk does not materialise, correct and optimal management is required. She cannot see down into her stoma in order to remove these secretions herself, whether by suction or forceps or otherwise. She is dependent on her carers to remove them for her, using either suction or forceps. Her carers are able to use suction and forceps below the entrance of her stoma and below the level of her voice valve. This is a practice that is approved by the SLT experts and can be performed safely by the Claimant's carers. This aspect of her stoma/airway care is required intermittently and unpredictably throughout the day and night. This has been the case since her laryngectomy and it continues. It will not change in future.

Voice valve management

184. The Claimant's voice valve must be cleaned after meals and on an ad-hoc basis throughout the day. The consequences of not cleaning the valve are loss or partial loss of voice and a risk of leakage of saliva/food/fluid into the lungs, with risk of chest infection. In order to clean the valve, it is necessary to be able to see it, in order to insert the brush into the valve accurately and avoid causing trauma to the tissues of her trachea and/or dislodging the valve. The Claimant can attempt to do this, but she is unable to see the valve sufficiently reliably to be able to do it accurately and therefore safely. She needs a carer to clean her valve for her.
185. When the Claimant's voice valve starts to leak, it needs to be changed. The Claimant experiences a higher than normal turnover of voice valves for a number of reasons. These include the way she uses her voice (something that is innate and difficult to modify), the fact that the puncture sits in tissue over which the peristaltic wave passes and the fact that the puncture sits in irradiated tissue which is friable and less able to sit snugly around the prosthesis.

186. If the Claimant's voice valve starts to leak, and if for any reason it cannot be changed, she must either drink thickened fluids, which she finds very unpleasant, or a stoma gastric tube must be inserted into the puncture by a carer, or a plug must be inserted by a carer to prevent leaks.
187. When the Claimant's valve needs to be changed, she is unable to change it herself.
188. Until late 2022, her valve changes were carried out by the SLTs at the hospital. Thereafter, the Claimant's carers have been changing her valve at home, with some very limited assistance from the Claimant.
189. The Claimant can remove an old valve provided the 'tail' of the valve is still attached and is sitting outside her stoma. She can also insert a 'lary tube' which stretches her stoma. Neither of these tasks is difficult.
190. However, the Claimant cannot reliably fit the gel cap onto the new valve. She is not particularly dextrous and she finds this extremely difficult to do. She is reliant on her carers for this aspect of a valve change. Further, and of central importance to a valve change, the Claimant cannot insert the new valve into the puncture and cannot visually confirm that the new valve is securely in the puncture/tract and is not leaking. She cannot reliably see the puncture, into which the new valve must be inserted, and she cannot insert a new valve by feel. She has attempted to insert a valve in the past, but has not been successful. She is reliant on her carers for these central aspects of a valve change.
191. The Claimant has been reliant on others to clean her valve and carry out her valve changes to date and will remain reliant on others in future.

Past need for, and provision of, care

192. I accept Professor Homer's description of the Claimant's injuries as life-changing and as representing a major disability.
193. The Claimant's care needs in relation to stoma/airway and voice valve management, as set out above, have been present since her laryngectomy. She has needed to have someone on hand at all times to assist her as and when required, during the day and also at night.
194. I accept her evidence and that of her carers that since she was discharged from hospital following her laryngectomy, she has been attended at all times by someone who has been able to provide her with stoma/airway care as described above. She has not always been attended by someone who has been able to change her valve.

Future need for care

195. The Claimant's care needs as set out above will be life-long. She reasonably requires 24 hour care to provide for these care needs. There is no realistic prospect of her condition improving or her ability to manage her condition improving such that she would not require care in future or would require less care in future.

ALLEGATIONS OF FUNDAMENTAL DISHONESTY

196. I turn now to consider the Defendant's allegations of fundamental dishonesty.

(i) 'Self-changer' allegation

Pleaded allegation

197. The Defendant's application to amend her Counter-Schedule to allege fundamental dishonesty was made by Application Notice dated 8 February 2024. It was supported by a witness statement from the Defendant's solicitor and a skeleton argument from counsel.

198. In each of these documents, the Defendant's flagship allegation of fundamental dishonesty was that the Claimant had dishonestly failed to declare that she had been changing her voice valves herself since December 2022. The Defendant's case was that the Claimant's evidence that she could not change her voice valve was dishonest. It was further the Defendant's case that if she was able to change her voice valve, she must also be able to manage her stoma and therefore her evidence that she could not do so was also dishonest.

199. However, that evidential picture subsequently changed. On 23 February 2024, the Claimant obtained a witness statement from Lindsay Lovell, which I have set out earlier in this judgment. This was followed by evidence from Freya Sparks and further evidence from the Claimant and her carers.

200. It is not necessary to recite the evidence and my findings. This allegation can be dealt with quite shortly. The Claimant cannot change her voice prosthesis on her own and she has not been doing so since December 2022 or at all. Her evidence that she cannot do so and has not been doing so is, in my judgement, entirely honest. The first allegation of fundamental dishonesty, as pleaded, is dismissed.

Allegation advanced in closing submissions.

201. In closing submissions, the Defendant has sought to re-cast this allegation. I note that this is not reflected in the Re-Amended Counter-Schedule, served after the close of the evidence.

202. The Defendant now argues that "the Claimant failed in her original Schedule of Loss and/or her witness statement to declare that she had been changing her voice prosthesis (with or without the assistance of a carer). This was dishonest."

203. In my view there is nothing in this allegation. The Claimant's case is that she cannot change her voice valve and is reliant on others. As I have found, she is unable to change her voice valve herself and has not been doing so. She is reliant on others to change her voice valve. The very limited tasks associated with a valve change that the Claimant is able to undertake herself do not make her any less reliant on others for a valve change. In my judgement there was nothing for her to declare. I reject the re-cast allegation that she has been dishonest.

(ii) & (iii) Allegations of fundamental dishonesty in relation to payments to her carers during lockdown 2020 and whilst she was on holiday

204. The second allegation of fundamental dishonesty is that during the first Covid lockdown in 2020, the Claimant dishonestly continued to pay her carers, notwithstanding the fact that the Claimant and her son Dayne were isolating and the carers were not visiting. The third allegation of fundamental dishonesty is that the Claimant dishonestly continued to pay her carers during periods when she went away on holiday, notwithstanding the fact that the carer(s) concerned did not accompany her on the holiday. These two allegations of fundamental dishonesty took up a very significant amount of time at trial, with the Claimant being subjected to very lengthy cross-examination about them.
205. I start with the observation that it is conspicuous that the Claimant makes no claim in respect of her paid care and therefore no claim in respect of her paid care during lockdown or her paid care whilst on holiday. The first question, therefore, is whether either of these allegations could properly give rise to a finding of fundamental dishonesty “in relation to the primary claim”, as required by Section 57 of the Criminal Justice and Courts Act 2015. The Defendant argues that they could for two reasons.
206. First, the Defendant relies upon an indemnity that was claimed in the original Schedule of Loss. Although the claim for an indemnity was subsequently removed when the Schedule of Loss was amended into its Re-Amended form, the Defendant contends, and I agree, that because it was included at one stage, it remains a valid target for an allegation of fundamental dishonesty. The Defendant contends that by the inclusion of this claim for an indemnity in the Schedule of Loss, the Claimant had incorporated her paid care into her claim.
207. The starting point is to consider what was actually being claimed by the indemnity. It was advanced in the Schedule of Loss as follows:
- “An indemnity is claimed under the principle in *Avon v Hooper* in respect of monies and assistance provided by third parties who may (in respect of past or future expenditure) reclaim payment or otherwise charge the Claimant for the same. The Claimant reserves the right to amend the Schedule on receipt from any such third parties of details of the cost of such provision.”
208. *Avon County Council v Hooper* [1997] 1 WLR 1605 was a case in which the Claimant, a minor who had suffered a severe and life-limiting birth injury, had been accommodated by his local authority for many years without charge. When the Claimant’s claim against the negligent health authority was settled, the settlement included an indemnity by which the Health Authority agreed to indemnify the Claimant (and his estate) against any sums he may be charged by the local authority for his past accommodation. The local authority then sought to charge the Claimant for that past accommodation pursuant to section 17 of the Health and Social Services and Social Security Adjudications Act 1983 and the Claimant in turn sought to enforce the indemnity against the Health Authority. The case turned on the interpretation of section 17 of the 1983 Act (which dealt with charges for local authority services) and whether it permitted the local authority to charge the Claimant for his past accommodation. The Court held that it did, which meant that the Health Authority was liable to indemnify the Claimant for those charges. The “principle in *Avon v Hooper*” therefore applied to

a situation where a local authority had provided services to a Claimant in the past for which it could have charged under section 17 but had not yet sought to do so, and in respect of which it could yet seek to impose a charge. That is not the position with the NHS. Indeed, in relation to an indemnity sought by the Defendant in relation to future losses, which I address below, the Defendant specifically relies on the non-means tested nature of the Claimant's NHS care. *Avon v Hooper* and Section 17 apply to local authorities, not to the NHS.

209. Such a conclusion is entirely consistent with the Defendant's own response to the claim for an indemnity, which was set out in her Counter-Schedule. Her pleaded response (which remains unaltered in the recently served Re-Amended Counter-Schedule) was as follows: "Denied. The case of *Avon County Council v Hooper* [1997] 1 WLR 1605 concerned charges being made under Section 17 of the Health and Social Services and Social Security Adjudications Act 1983 for services otherwise provided under other specified statutory provisions. The effective statutory services that applied in Avon have all since been repealed and withdrawn, and all that is left in the Act is limited to charges for services provided under paragraph 1 of Part II of Schedule 9 to that Act, namely the provision of meals and recreation for old people, which services do not arise in the present claim. The Claimant pleads no statutory basis or risk for the local authority recovering any payments made or otherwise making any other charges in due course, absent which statutory basis or risk, there is no basis for an indemnity. Further, in Avon, the indemnity arose by agreement, so Avon is not any authority for the Court having jurisdiction to impose such an indemnity, which jurisdiction it is denied that the Court has. Further, where the funding that the Claimant has managed to secure from the local authority is so vastly in excess of what she might have needed or might now need as a result of her laryngectomy and any negligence, so it is denied that the Defendant can be under any obligation to indemnify against any recovery by the local authority."
210. In my judgement the indemnity that was sought in the Schedule of Loss was limited to local authority charges, had such been made. Even then (and adopting the Defendant's analysis of what remains of the 1983 Act), it could only apply to a charge for "the provision of meals and recreation for old people, which services do not arise in the present claim".
211. The local authority ceased to fund the Claimant's care in September 2018. Thereafter, all funding came from the NHS. The allegations of fundamental dishonesty in relation to payments to carers during lockdown and whilst the Claimant was on holiday all post-date September 2018. Lockdown was in 2020. The earliest holiday in respect of which an allegation is made was in December 2018. Even if I had found there to be dishonesty in connection with such payments (which I do not – see below), in my judgement they were not within the scope of the indemnity sought and could not be said to relate to the primary claim.
212. The second way in which it is said that the payment of carers during lockdown and during periods of holiday "is relevant to the primary claim" is put as follows in the Defendant's Amended Counter-Schedule: "it goes... to the heart of the future care claim because the past and present care regimes are the foundation of the alleged future care regime." I disagree. The claim for past gratuitous care turns on a determination of what has actually been provided by way of gratuitous care and whether the same was reasonably required as a result of the Claimant's injuries. The claim for future care turns

on a determination of the extent of the Claimant's future care needs and what is reasonably required to meet those needs. Neither of these claims depends to any extent on whether carers who (it is agreed) did not provide care during lockdown and whilst the Claimant was on holiday were nevertheless paid. The issue in relation to these periods is whether the Claimant needed and received care during lockdown and whilst on holiday. By way of illustration, during lockdown the Claimant isolated at home with her son Dayne. The issues so far as the claim for past gratuitous care is concerned are what care did the Claimant receive from Dayne during this period and was it reasonably required as a result of her injuries. The question of whether there were other carers who were not providing care but were nevertheless being paid, is not relevant to the primary claim.

213. For these reasons, it is my judgement that payments to carers during lockdown and payments to carers whilst the Claimant was on holiday are not relevant to the primary claim and therefore neither is capable of forming the basis of a finding of fundamental dishonesty. All that said, for completeness I will consider the allegations and set out my findings.
214. As a precursor to that consideration, I remind myself that the Claimant was not bringing a claim in respect of her paid care and the allegations of fundamental dishonesty relating to it were only added to the Counter-Schedule by amendment 10 days before trial. The cross-examination of her was based heavily on documentation from several years ago. For the most part she was able to answer the questions put, although there were occasions when she was unable to explain an entry, or a seemingly anomalous figure. I do not consider this surprising, nor do I consider it to be, by itself, indicative of dishonesty. The allegations of dishonesty do not turn on an anomalous figure here or an unexplained entry there.

(ii) Paying carers during lockdown

215. I start with the second allegation of fundamental dishonesty relating to the payment of carers during lockdown in 2020.
216. There is no dispute that during the first Covid lockdown in 2020, the Claimant was a high-risk individual and she and her son Dayne isolated at the Claimant's home and he became her sole carer. Her usual carers did not attend, yet she continued to pay them.
217. The Claimant's evidence was that she contacted CHC and asked them what to do and they told her to continue to pay her carers as normal, which was what she did. The Defendant accuses her of lying about her conversation with CHC.
218. The Claimant continued to submit invoices on behalf of her carers setting out the hours that they would have worked but for lockdown, but she did not state on the face of those invoices that the carers concerned were not working. The Defendant accuses her of dishonesty in the submission of these invoices.
219. In the course of the litigation, the Defendant made a Part 18 request in which she asked the Claimant about the hours worked by certain carers during certain weeks. Some of those weeks were during lockdown. The Claimant's answers repeated the hours that had been stated on the invoices, without stating that the carers were not in fact working. The Defendant accuses her of dishonesty in her Part 18 replies.

220. The starting point, and the key determinant of honesty/dishonesty in relation to the payment of carers during lockdown, is the question of what, if anything, she was told to do by CHC. The Claimant gave evidence that she telephoned CHC at the start of lockdown and informed them that her carers were not going to be working through lockdown and she asked what she should do. CHC told her to continue paying her carers. CHC told her that they were going to continue to pay the money and she should continue to pay her carers until they advised her to do otherwise. She said that she continued to pay her carers. She said that it would have been dishonest if she had kept the money herself, but she did not do that. She commented that her carers were not “some zero hours people”, they were her loyal team and she thought she was being fair to them, which was what she was advised to do.
221. Helen Howison, care expert, gave evidence that government guidance for people receiving direct payments during the pandemic provided that, where possible, they should continue to use their direct payments as agreed in their care and support plan but there may be situations where they need to organise their care and support in different ways as a result of the pandemic. There was an expectation that CCGs would be as flexible as possible with the aim of keeping people safe and avoiding care breaking down. Whilst this guidance does not address the Claimant’s specific situation, it is indicative of a much more flexible approach being adopted during the pandemic. In my judgement it broadly supports rather than contradicts the Claimant’s evidence of what she was told and what she did.
222. The Defendant did not call any evidence from CHC or anyone else to contradict the Claimant’s evidence (notwithstanding the fact that the names and contact details of individuals connected to the CHC funding are contained within the documents before the court) and there is no evidence of any broad policy statements from CHC that contradict the Claimant’s and Mrs Howison’s evidence.
223. What the Defendant did was cross-examine the Claimant about emails she had exchanged with the local authority about obtaining PPE for her carers, the emails beginning on 20 March 2020. It was put to the Claimant that the local authority was funding her care at that time and here she was emailing her funders at the start of lockdown, yet in the emails she did not tell them that her carers were not coming in and her funders did not tell her that she could continue to pay her carers anyway. Unfortunately what was being put to the Claimant was inaccurate, although I accept this was not deliberate. In fact the Claimant’s care had been funded by CHC, and not the local authority, since September 2018. Notwithstanding what was being put, the Claimant’s immediate and clear answer was that it was CHC and not the local authority that she spoke to about her carers not coming in. She said this more than once, but each time she said it, she was contradicted by counsel. Eventually this led the Claimant to doubt her initial answers, although when the confusion of the cross-examination had settled, she returned to her recollection that it was CHC she had spoken to, not the local authority. In my judgement two things flow from this cross-examination. First, the fact that she did not discuss the payment of carers with the local authority, who were not funding her care, does not undermine her evidence about her conversation with CHC. Second, her clear and repeated evidence that she had spoken to CHC and they had told her to carry on paying her carers, in the face of (inadvertently) misleading assertions being put to her, served to support rather than undermine her evidence about her conversation with CHC.

224. So far as the submission of invoices was concerned, it is necessary to consider what normally happened and then what happened during lockdown.
225. In normal times, a carer would be paid if she was working, or if she was on paid holiday or if she was working as cover for someone who was on paid holiday. The system for making payments and submitting invoices was as follows. CHC allocated the Claimant a budget, from which she had to pay for her care. Each month, CHC would automatically make a payment into an online portal. The Claimant did not have to request this, it happened automatically. She was then able to access that portal and make payments out directly to her carers. If there was a recurring payment (for example to a carer who was a PAYE employee), she could set up a payment request for, for example, 6 months and then the payment would go out to the carer on the same day each month for 6 months. Otherwise she would make individual payments each month. Every 3 months there was an audit and the Claimant had to submit invoices for the self-employed carers to show where the money had gone. A large number of such invoices are in the trial bundle and they follow a standard format. They contain, amongst other details, the name and address of the carer, the period to which the invoice relates, the number of hours worked and the hourly rate and the total due to the carer. They also show the bank account into which payment has been made. She said that the CHC auditor was always very complimentary about her record keeping.
226. When Covid struck and lockdown was imposed and the Claimant had to isolate with her son Dayne, she said that she spoke to CHC and was advised that her budget would not be affected. She said she was advised to continue to pay her carers as normal. I have already considered the evidence in relation to that. The Claimant explained that she normally did a holiday plan about 3 months in advance because it was wise to ensure that she had her carers' holidays adequately covered. She said that when lockdown occurred, she continued to pay her carers as she would have done if there had been no lockdown. Where carers had been rostered to work, they were paid as usual even though they were not coming in. Where carers already had holidays booked, those holidays were retained and not cancelled, and she continued to pay them in the same way that she would usually pay her carers during their holidays. The Claimant said that it would have been a problem if no one had taken holiday during lockdown and then, when she needed her carers again post-lockdown, they all still had lots of holiday to take. Where a carer was already rostered to provide holiday cover, and at that time it was always Annie Courtney who covered holidays and sickness, the Claimant continued to pay her as well. In other words, the payments were exactly the same as they would have been in the absence of lockdown. So, by way of example, the Claimant was asked about holiday that Anna Crowley had booked from 6th to 11th April 2020 and which was to have been covered by Annie Courtney. Both were paid. The Claimant said that that was what had already been arranged and so she honoured it. This was the basis upon which payments were made. So far as the invoices were concerned, the Claimant said that she continued to be obliged to submit them every 3 months to CHC, which she did. She did the invoices as normal, putting on them the hours that the carer would have been working if it had not been lockdown and for which the carer had been paid. The invoices did not state that the carer concerned was not working because it was lockdown.
227. On 18 October 2023 the Defendant put a large number of Part 18 questions to the Claimant. There were 36 questions, but under each question, there was a series of

further questions, such that, by my count, there were 189 questions in total. A very large number of them referred to PAYE records and invoices relating to the Claimant's carers, requiring the Claimant to look at records and transpose the contents of the records into her answers. Amongst those questions, she was asked (questions 18-21) about 3 invoices for Annie Courtney that related to April, May and June 2020 and 1 invoice for Dayne Cullen relating to April 2020. In relation to Annie Courtney's invoices, which stated that she was being paid for providing sickness and holiday cover and which stated the number of hours for which she was paid, the Claimant was asked a number of questions, in particular what hours Annie Courtney worked and for details of the holidays that she was covering. In relation to Dayne Cullen's invoice, which also stated the number of hours for which he was paid, the Claimant was asked a number of questions that related to general matters and to other months, but she was also asked how many hours Dayne actually worked that month. The questions did not identify the period as being one of lockdown, nor did the questions identify, or ask for explanation of, any inconsistency between the Claimant's witness statement about lockdown and the invoices (both of which the Defendant had by that stage). Mr Hough criticises them as badly drafted or trick questions. I observe that litigation is adversarial and the Defendant was entitled to ask the questions as she saw fit. However, with the benefit of hindsight, it seems to me that the whole exercise was very vulnerable to an element of document fatigue, with the Claimant mechanically reciting what was on the invoices without much additional thought, and with that risk increasing as she worked her way through the very long list of questions. In her answers, the Claimant gave answers in accordance with what was on the face of the invoice. She did not say that she was isolating with Dayne and her other carers were not coming in.

228. There were other questions (questions 12-17) about PAYE records for the year April 2020 to March 2021. Whilst that year included April to June 2020, the questions did not distinguish between months and asked general questions about the whole period. There were also questions (questions 28-29) about invoices for Annie Courtney and Dayne Cullen for January 2021. However there was no clear evidence that the Claimant isolated with Dayne during that lockdown and the Claimant was not asked about those invoices. In the circumstances I do not consider them further, although the general analysis below would apply.
229. The Claimant was cross-examined about why she had answered the Part 18 questions about April to June 2020 as she did. Unfortunately the issues of whether her carers came in, whether she paid them, why she paid them etc blurred with the narrow question of why she answered the Part 18 Request as she did. However she did say that she thought she had misinterpreted the questions and had thought that, because she had paid her carers, the Defendant was asking her how much she had paid, how many hours and what the hours were. She said that if she had made a mistake she apologised but she was adamant there had been no deceit or dishonesty.
230. I bear firmly in mind that the Claimant had made no secret of the fact that she had been isolating with Dayne and her carers had not been coming in. In her witness statement dated 23 May 2023 she said: "When the COVID-19 pandemic began, my situation became unbearable: I was advised to shield, the risk of infection was very high and no one could come into my house. My son and I isolated and he became my full time carer again for several months." Dayne Cullen said the same thing in his witness statement dated 11 May 2023. These statements had been served by the time of the Part 18

Request. The Claimant had also said the same thing to the experts instructed in the case. For example in her report dated June 2023, Helen Howison recorded “son met all care needs in isolation through Covid-19 lockdown, funding continued” and later in the report she recorded that “when the national lockdown occurred in March 2020 Wilma was clinically vulnerable and Dayne once again became her sole carer without any respite. By July 2020 local services had begun to make appropriate arrangements for PPE and covid testing so that staff could resume their duties.” By way of further example, in her report dated June 2023, Dr Carstairs recorded the care arrangements in place prior to March 2020 and then recorded that “[a]ll this came to an abrupt end in March 2020 when the pandemic restrictions were put in place and Dayne and Ms Cullen had to isolate; Dayne became the sole carer again until July when care staff were allowed to work again.” These reports were served well before the Part 18 Request was made. To my mind these statements and reports are not consistent with the suggestion that the Claimant has set out to give the impression that her carers continued to attend throughout lockdown.

231. The Defendant alleges that the Claimant has lied about the conversation with CHC, that she was dishonest in her submission of invoices for carers during lockdown and that she has subsequently tried to cover that up with dishonest Part 18 replies.
232. I start with the telephone conversation with CHC. On the evidence before me, I find that the Claimant did telephone CHC at the start of lockdown and was told to continue to pay her carers as usual, until advised to do otherwise. I found her evidence on this issue convincing, it was supported by the broad policy statements identified by Helen Howison, it was not undermined by the contemporaneous emails with the local authority and it was consistent with her continuing to submit invoices in exactly the same way as she normally did. It follows that I do not find her to be dishonest in the submission of invoices in relation to the period of lockdown. This was what she had been told to do by her funder. That being so, there was no reason for her to state on the face of the invoices that the carers were not attending due to covid, because her funder already knew that to be the case. So far as the Part 18 replies are concerned, I reject the allegation that she “fabricated” her replies. If it had been her intention to mislead the Defendant into thinking that her carers had attended upon her throughout lockdown, she would not have made the witness statement that she did in May 2023 and she would not have told Helen Howison and Dr Carstairs that she and Dayne had isolated together during lockdown. I accept her explanation for her Part 18 replies. For all these reasons, I reject the allegation that the Claimant has been dishonest in relation to the payment of her carers during lockdown.

(iii) Paying her carers whilst she was on holiday

233. I turn to the third allegation of fundamental dishonesty relating to the payment of carers during periods when the Claimant was away on holiday without the carer concerned.
234. Pre-laryngectomy, the Claimant travelled widely. Post-laryngectomy, as soon as she was able, she resumed trips abroad, accompanied by people who could provide her with care. Since September 2018, she has been in receipt of funding to pay for carers from CHC. The allegation that was being put in cross-examination, exhaustively and at times with considerable hostility, in respect of every trip and invoice, was that it was dishonest to go on holiday and use her funding to pay her carers who did not go with her. The answer was the same from first to last, and was consistent with the documentary

evidence, namely that she always paid her carers when she went away on holiday. The Claimant explained that her carers were booked many months in advance and they should not be penalised if she went on holiday. It was only fair to pay them. She said that they are not going to work for you if you tell them that when you go on holiday, they are not going to be paid. She had already said that her carers were not some zero hours people that you can pay or not pay as you wish. She said “you can’t just pick up your carers and drop them and pick them up and drop them. You just can’t do that to people. I choose to go on holiday. They didn’t choose to have the holiday at that time. So I pay my carers when I’m on holiday.” She said that if you did pick them up and drop them as was being suggested, “you wouldn’t get anybody working for you”. She said that she paid them for the hours that they had been scheduled to work but were not now required to work because she was away. She did the same if they were due to be on paid holiday themselves and if they were due to be providing holiday cover. In other words, if there was an expectation that they would be paid and she then went on holiday, she continued to pay them regardless of the fact that she was away. So far as her day to day care whilst she was away was concerned, this was provided by those she travelled with and she always travelled with someone who knew how to provide her care. She did not pay them for this.

235. She prepared the invoices as she normally would (and as she did through lockdown). She said that she was audited every 3 months and she had to show the person who managed the funds where the money had gone and the invoices did that, and she had to show that it went into that person’s bank account, which again she did. She said that the auditor was always very complimentary about her record keeping. She was asked whether she told her funders about paying her carers whilst she was away and she said that she was not aware that she had to tell them. If she had been told she had to do so, then she would have done, but it did not occur to her that she needed to. She said that the auditor knew that she went away on holiday.
236. The Defendant did not call any evidence from CHC to the effect that this arrangement was impermissible. Again I observe that the contact details of individuals at CHC are contained within the documentation. Instead the Defendant contends that this impermissibility and therefore the Claimant’s dishonesty is clear from the terms of the agreement between the Claimant and CHC (the holidays that were the subject of criticism by the Defendant all post-dated CHC becoming the funder of the Claimant’s care). When CHC took over the funding of the Claimant’s care, they wrote to her explaining her options. One of the options was to have a Personal Health Budget, which was described as “an amount of money to support your identified health and wellbeing needs, planned and agreed between you and your local NHS team. The plan sets out your personal health and wellbeing needs, the health outcomes you want to achieve, the amount of money in the budget and how you are going to spend it. If you choose to have your personal health budget as a direct payment then you will be responsible for managing the allocation of funds/how you use them to meet your assessed care needs.” This was the option that the Claimant chose and she subsequently signed a Direct Payments Agreement with CHC in which, under the heading “What you will do”, it stated “use your direct payments to achieve agreed personal goals/outcomes”.
237. I have considered these documents carefully and I cannot see that the Claimant’s use of her budget is incompatible with them. I accept her evidence that she needed a reliable team of carers and I further accept her evidence that it would have been impossible to

engage and retain a reliable team of carers if, every time the Claimant went away, the carers' scheduled work was cancelled and they were left unpaid. There may be more than one way of achieving the goal of a reliable team of carers, but there is no evidence that the Claimant's solution was or would have been disapproved by CHC and in my judgement it is well within the range of reasonable solutions available to her. Furthermore, it has, in my judgement, enabled her to retain a loyal team of carers and thereby "to meet [her] assessed care needs" and "achieve agreed personal goals/outcomes". I reject the allegation that she has been dishonest in her payment of her carers when she has been away and they have not been with her.

(iv) Defendant's surveillance evidence

238. The fourth allegation of fundamental dishonesty is that the Claimant's claim that she requires 24 hour attendance is dishonest and that the same is established by the Defendant's surveillance evidence. I have already considered the surveillance footage in detail. For the reasons set out earlier in this judgment, I reject the submission that it disproves the Claimant's claim and/or proves that she has been dishonest.

(v) Claim for a stairlift

239. This is the fifth pleaded allegation of fundamental dishonesty. The Claimant's Schedule of Loss included a claim for a stairlift, advanced on the basis that the Claimant gets out of breath when using the stairs in her home. The Defendant relies on what the Claimant is recorded to have said at an appointment with a consultant on 28 March 2023. She had been referred on an urgent 2-week-wait basis because of suspected lung cancer. In the notes from that appointment, it is recorded "no issues with SOB" and "no issues with stairs". In the consultant's subsequent letter to the GP, she says that the Claimant has been well otherwise with no noticeable breathlessness. The Defendant contends that this entry in the records is inconsistent with the claim for a stairlift such that the claim must be dishonest. There were no closing submissions in respect of this allegation.

240. The claim for a stairlift was advanced on the basis that the Claimant had taken advice from a local occupational therapist about further steps that could be taken to make her home more accessible and this led to the obtaining of an estimate for two stairlifts at a total cost of £6,540. With annual servicing costs, this produced a claim of £16,151.91. At trial, the Claimant was cross-examined and she said that she did get out of breath and she had been advised to install stairlifts for when she gets older.

241. None of the respiratory experts gave evidence at trial. I have considered their written reports and joint statements.

242. When Dr Evans, consultant in respiratory medicine, saw her on 17 June 2022, he recorded her as reporting "breathlessness walking up inclines and climbing a flight of stairs". He observed that "the medical records reviewed since my examination of Mrs Cullen endorse this condition." He did not express any reservations about this reported breathlessness. When Dr Barnes, consultant respiratory and general physician, saw her on 30 September 2022, he recorded her as having no problems with breathlessness, yet in the opinion section of his report he said that the exercise tolerance that she reported to him would be MRC Grade 2. In their joint statement, Dr Evans considered that she had 20% respiratory disability. Dr Barnes estimated ongoing MRC grade 2. Neither

expressed any concerns about the apparent variation in what had been reported to each of them.

243. Ms Ruth Ainley, respiratory physiotherapist, assessed the Claimant at her home on 20 October 2022. Ms Ainley recorded there being a flight of steps to the front door of the building, 2 flights of stairs within the building to reach the Claimant's front door and a further 2 flights within the Claimant's home (there are photographs showing these flights of stairs within Mrs Howison's report). Ms Ainley recorded that the Claimant has some breathlessness on exertion, most notably when climbing a flight of stairs. Ms Ainley recorded the findings of her examination of the Claimant. She recorded that the Claimant was not breathless at rest. She assessed her ability to climb 2 flights of stairs and she recorded "able to climb stairs: breathless but able to talk. Recovered in approximately 2 minutes."
244. Ms Holly Spencer, respiratory physiotherapist, assessed the Claimant at her home on 31 January 2023. She noted Ms Ainley's findings on climbing stairs and said that this level of breathlessness was not noted during her assessment. She did not specify the nature of her own assessment. However she observed that breathlessness can vary due to a multitude of factors and so Ms Ainley's findings could have been an accurate representation of the Claimant's breathlessness at that point.
245. In their joint statement they agreed that the Claimant's MRC grade at the time of assessment was 2 (or modified MRC grade 1), consistent with shortness of breath when walking up a slight hill. They agreed that their assessments of her breathlessness on exertion differed, but they agreed that this would be within a normal variation of an individual's breathlessness and could be attributable to the Claimant's health on the given day. They agreed that the use of exercise equipment such as an exercise bike would benefit the Claimant. They agreed that a stairlift was not required.
246. The claim for a stairlift was therefore not supported by the expert evidence and it was subsequently removed from the Schedule of Loss.
247. Turning to the allegation and starting with a general observation. The background to this head of claim is that the Claimant was a life-long heavy smoker who now has COPD. There are also references in the medical records going back many years to asthma or suspected asthma. As a result of her laryngectomy, she has decreased humidification of her airways, resulting in more viscous secretions. As a general proposition, in view of this background it would not be especially surprising if she experienced some degree of breathless on climbing stairs. If I then look at the expert respiratory evidence in the case, I observe that all four of the respiratory experts express the view that the Claimant's MRC score would be consistent with (at least) breathlessness on walking up a slight hill. It is difficult to see how that differs greatly from walking up 2 flights of steep stairs. If I then look at the Claimant's observed ability to climb stairs, the best evidence of that comes from the respiratory physiotherapists. As between their reports, if I were required to choose between their findings, I would prefer those of Ms Ainley because she has actually set out what she got the Claimant to do, and what she observed. Ms Spencer's report is not so specific. However it is not necessary to prefer one over the other because they are agreed that their respective findings are within the normal variation of an individual's breathlessness. That, to my mind, explains the variability of reported breathlessness to Dr Evans and Dr Barnes, and the entry in the medical records upon which the Defendant relies. It also explains the lack of reservation in the

joint report of Dr Evans/Dr Barnes in relation to the different reports that they received. Against such a background, and the Claimant's evidence that she had been recommended a stairlift by a local occupational therapist, it is unremarkable that it was included in the claim, and equally unremarkable that it was withdrawn when it was not supported by the respiratory physiotherapists. In all the circumstances, I cannot see that the claim was in any way dishonest.

(vi) Claim for loss of amenity

248. The sixth and final pleaded allegation of fundamental dishonesty is an allegation that, in her witness statement and in her Schedule of Loss, the Claimant has dishonestly misrepresented her loss of amenity and in particular her social life and that this is demonstrated by her Facebook posts. The Defendant alleges that "the Claimant's Facebook posts show that between the end of 2017 and the beginning of 2023 she regularly (1) went out and socialised, (2) socialised at home, (3) cared for her grandchildren, (4) travelled abroad and (5) enjoyed eating and cooking spicy food."

Effects on social life

249. It is first necessary to understand what the Claimant's social life was like pre-laryngectomy. There is a good deal of detail in her witness statement and in the various medical reports and in the witness statements of others. There was no challenge to this part of the evidence. Pre-laryngectomy, the Claimant was a highly social, free-spirited individual. She described herself in her witness statement as a fun loving, outgoing, gregarious person with a full and active social life. She enjoyed meeting up with friends several times a week, for example to go open swimming and going for a sauna afterwards. She used to enjoy activities such as cycling and jogging. She used to regularly meet with friends for a drink in the local pub and often went out for meals. Indeed in her evidence at trial she described herself as being out every night playing pool, playing darts and going to clubs. She was evidently a very confident person who used to love singing and enjoyed karaoke and would often run karaoke sessions on behalf of friends for parties and for the local youth charity family fun days. She had an enthusiasm for performing her own poetry at open mic events. She used to love social occasions and had a passion for cooking and food. She used to enjoy making a meal and having a lot of people round to share it. She was actively involved in the development of a local youth group, helping them gain charitable status and being very actively involved in attending meetings, including residential weekends and activity trips, and helping to organise community fun days and other events.
250. Following her laryngectomy, the evidence is that these activities have been very significantly curtailed.
251. In her witness statement she described how her involvement in the local youth charity has all but ended and this makes her sad. There is no dispute about this and there is inevitably a loss of socialisation as a result.
252. She can no longer swim, use a sauna, cycle or jog. She cannot take part in activities with her friends and family and she feels sad that she cannot take her grandchildren to the park and cannot join in any water activities with them. For the most part, there was no challenge to this part of her evidence. The only challenge related to an entry on her Facebook page which, it was alleged, indicated that on one occasion in August 2022

she had been dancing in the rain whilst on holiday with friends. Pausing there, it is difficult to see how this contradicts her evidence about not being able to swim or take part in water activities with her grandchildren, but in any event, the Claimant said that she would not do it for fear of getting water in her stoma. There was a thumbnail of a video that accompanied the Facebook post. The Claimant said that she was not sure that the person in the thumbnail was her. The video was not in evidence. The Claimant was asked to look for the video during the trial and said that she could not find it. The Defendant made much of her failure to produce the video, accusing her of dishonesty in cross-examination and again in written closing submissions. That being so, it was very surprising to be told in the course of oral closing submissions that the Defendant's solicitors had in fact had the video in their possession during the trial. They had not previously mentioned this to counsel or the court, and it has not been disclosed or relied upon, despite the fact that the Defendant bears the burden of proof in relation to fundamental dishonesty. In all these circumstances, I conclude that this post does not support an allegation of dishonesty.

253. She also says that she can only manage certain foods and she takes longer to eat than everyone else. She finds that her stoma and valve care are socially embarrassing and she feels agitated having to do them in public. She describes how this has led to her starting to lose confidence in herself and she has become withdrawn. She now prefers friends and family to come to her rather than go to a restaurant as it is less problematic. She used to love social occasions but she now describes being reluctant to go out and feeling quite socially excluded. Apart from her carers, she does not really see many people. The Claimant was cross-examined about socialising and going to restaurants. In the Defendant's closing submissions, it is said "the Claimant's evidence when cross-examined about [her social media posts] was that she socialised only for celebrations birthdays and anniversaries". That was not how I understood her evidence. It was put to her in cross-examination: "But you have socialised over the years since 2017? You have been out to restaurants, have you not?", to which she replied "For celebrations, birthdays, anniversaries, yes, yes I have." I understood her answer to refer to restaurants, not the whole of her socialising. She said that she does occasionally go to restaurants but she said that there are 365 days in the year and she only goes out on a few of them. In closing the Defendant points to 46 Facebook entries that indicate socialising of one sort or another. They span a period of 4 years, which equates to approximately 12 times a year, although I bear in mind that over the 6 years for which the Defendant has obtained her Facebook posts, it is less frequent still. On any view this is a very significant reduction from her pre-laryngectomy social life where she was out almost every night. This reduction is consistent, in my view, with the social embarrassment and agitation which I accept she experiences when undergoing stoma and/or valve care in a public place. It is also consistent with her evidence that she takes longer than other people to eat a meal, which in turn is consistent with the agreed SLT evidence that she has mild dysphagia. It is also consistent with a loss of confidence generally, which in turn is consistent with Professor Homer's evidence that having a laryngectomy is a life-changing event that has a significant effect on image and self-confidence. In my judgement her description of becoming withdrawn and preferring friends and family to come to her has to be compared to her pre-laryngectomy lifestyle and when that is done, it is not inconsistent with the Facebook posts.

254. She says that she can no longer sing, do karaoke or recite poetry. She has stopped writing poetry due to depression and not being able to recite it anymore. There can be

no dispute about her inability to sing or recite her poetry and the associated loss of socialisation.

255. So far as communication is concerned, she says that she finds simple interactions with people hard. People often find it difficult to understand her as her verbal communication skills are now poor. If she does speak to somebody and they do not understand her properly, they often ignore her and speak to her carers instead, thinking that she must be deaf. She feels angry and humiliated when this happens. This evidence was not disputed and, having spent several days listening to her give evidence, there can be no dispute that although she is able to speak using a voice valve, she does not have anything approaching a normal voice and her communication skills are now significantly impaired. I accept that this limits her ability and willingness to socialise.
256. So far as having lots of people round is concerned, she said that that does not happen much now. There is no evidence to the contrary in the Facebook posts.
257. For the reasons set out above, and viewing the evidence in the round, I reject the suggestion that the Claimant has dishonestly misrepresented the extent to which she has suffered a loss of social life.

Caring for her grandchildren

258. The Defendant asserts that the Claimant has misrepresented her ability to care for her grandchildren, saying in her Schedule of Loss that she “bitterly misses her usual pleasurable activities, including... caring for her grandchildren”. The Defendant then refers to 13 Facebook posts, spread over 2 years, in which she says that she was either looking after her grandchildren or had them staying at her home. It is said that the two are inconsistent and demonstrative of dishonesty.
259. In fact the evidential picture is more nuanced than the brief summary in the Schedule of Loss. In her witness statement dated 18 May 2023, she said “I am sad that I cannot take my grandchildren to the park and join them in any water activities, something I used to love doing. They in turn find it difficult to understand why I cannot join in activities with them.” In her evidence at trial she said that she saw her grandchildren every week, sometimes twice a week, but not on her own. She said she could not care for them on her own because if something happened to her when she was in charge, that could be dangerous for them. She said that she would love to take them to the park and do things with them but she cannot. She said that she looked after her grandchildren with her family.
260. Danny Cullen, the Claimant’s son and the father of the Claimant’s grandchildren, gave evidence that the Claimant loved to see her grandchildren and so sometimes when he was going to look after his mother, he would take his children with him. He and his children would be there together and they would all stay overnight. His evidence was not challenged.
261. I accept the evidence that the Claimant did not look after her grandchildren on her own and that her ability to engage with them as she would have wished has been significantly impaired by her injuries. I reject the suggestion that her evidence on this issue is undermined by her Facebook posts.

Travelling abroad

262. This is not an allegation based not so much on the Facebook posts but on the bare fact of the Claimant taking holidays post-laryngectomy. In closing the Defendant alleges that the Claimant's evidence in two parts of her witness statement dated 23 May 2023 and in what she told Professor Homer at the time of his assessment are contradicted by the number of holidays she has taken since her laryngectomy. The Defendant asserts that the Claimant has taken 17 holidays in this period. The Claimant drew a distinction between going on holiday and going to visit her family and I accept that distinction, which reduces the number to 14 over a period of 6 years. That equates to just over 2 holidays per year.
263. In closing submissions, the two parts of the Claimant's witness statement are quoted as follows: "The Claimant's evidence was that (1) she used to regularly meet with friends to go for a drink in the local and go out for meals" (paragraph 46) and "she used to love social occasions but is now reluctant to go, she feels quite socially excluded" (paragraph 48). The Defendant says they are incompatible with her holidays. However it seems to me that it would be wrong to take these two extracts in isolation and use them for comparison purposes. They must be read alongside the statement as a whole and paragraphs 63 and 64 in particular, in which she described her holidays. She described her pre-laryngectomy love of travel and spending time abroad. She went on to say that, post-laryngectomy, one of the things that had helped her a lot, when she was well enough, was being able to travel again. She then went on to describe a number of trips that she had taken. She did not include every trip in that paragraph, but she included descriptions of trips to Australia, India, Jamaica, Thailand, Portugal and New York. She was clearly not seeking to present herself as someone who was unable to travel. What she did say was that she had to have someone with her who was able to manage her care and she travelled with carers, friends and family members who had provided her with the necessary care. It seems to me that paragraphs 46 and 48 are not incompatible with paragraphs 63 and 64. They must simply be read alongside one another, together with the remainder of her statement, in order to get the full picture, which is more nuanced than the Defendant seeks to suggest and is not inconsistent with the taking of holidays.
264. As for the extract from Professor Homer's report, he recorded the Claimant as saying that her injury "drastically changed the quality of her life. She was a very social outward looking person and the effect of laryngectomy and limitation that it imposes, particularly on voicing, had significantly affected this. She describes periods of low mood and difficulties in adjusting to her circumstances". It seems to me that this is entirely consistent with her witness statement taken as a whole, in which she describes a pre-laryngectomy lifestyle that was active and highly social and included many activities that she can no longer do. Professor Homer highlights that the limitation is 'particularly on voicing'. This is not controversial. Quite apart from the social difficulties associated with having to speak through a voice valve, there are specific activities such as a love of singing, karaoke and performing her own poetry at open mic sessions that she can no longer do. These are all things that significantly and adversely affect her quality of life and her ability to socialise. None of this prevents her from, or is inconsistent with, taking holidays.
265. In the circumstances, I reject the allegation that the Claimant's evidence is demonstrated to be dishonest by the fact that she has taken holidays post-laryngectomy.

266. A small but related point which Ms Palmer considered counted against the Claimant was the fact that when she assessed the Claimant, the Claimant had not mentioned all the holidays she had taken since her laryngectomy. In her report, Ms Palmer listed the holidays that had been taken in order to emphasise what she saw as the Claimant's failure. When asked at trial where she had got the list of holidays from, Ms Palmer replied that she had taken it from the Claimant's own Schedule of Loss (and I observe that the same appears in the Claimant's witness statement) which, to my mind, completely neutralises the point.

Cooking and eating spicy food

267. In her Amended Counter-Schedule, the Defendant quotes from the Claimant's witness statement dated 18 May 2023, in particular paragraph 42: "I used to really enjoy cooking and would often cook for family functions. I am now limited in what ingredients I can use because spices and strongly aromatic foods make me cough"; and paragraph 50: "One of my passions was food and cooking. One of the things I really enjoyed was making a meal and having lots of people round. That doesn't happen much now. I cannot enjoy food myself so much now, I have an altered sense of smell and things just don't taste the same anymore." In closing the Defendant also refers to the Schedule of Loss where this evidence is summarised and to the Claimant's evidence at trial in which she said that she does not cook like she used to cook and she does not cook for events. The Defendant submits that the Facebook posts contradict her witness statement and Schedule of Loss such that the claim is fundamentally dishonest.
268. I note that the evidence of Anna Crowley and Dayne Cullen is consistent with the Claimant's evidence. In her witness statement dated 22 July 2022, Anna Crowley said that the Claimant could not use certain ingredients because they affect her stoma and make her cough and that whereas the Claimant was previously an avid cook and used to enjoy hosting dinner parties, she no longer does so. At the time of Helen Howison's assessment in August 2022, Dayne Cullen described the daily routine in which he said that the Claimant "can't cook over steaming pans or tolerate spices being fried as irritates her airway causing her to cough".
269. I note also that the Claimant's own account to the experts is consistent with her witness statement. By way of example, when she spoke to Marie Palmer in October 2022, she said that she previously did her own cooking and that she was a good cook, including cooking Indian food from scratch. She now does very little cooking and cannot make Indian food as the spices are an irritant. She reported that Anna is a good cook and makes food. When she spoke to Dr Carstairs in December 2022, she said that she cannot cook with strong spices and this is a real loss because she used to enjoy cooking Indian food but now the chilli irritates her throat and makes her cough so she cannot do it. She used to love to have people round for dinner and to cook an Indian meal from scratch but she cannot now do this. When she spoke to Ms Heathcote in March 2023, she said that cooking fumes triggered coughing episodes and Ms Heathcote observed that "it is common for laryngectomy patients to cough due to exposure to irritants such as cooking fumes."
270. Her evidence at trial was also consistent with her witness statement. In the course of cross-examination she said that she used to love really spicy food and she cannot cook it any more. She cannot eat very strong spices, but she can eat things that are not very

hot, herbs more than spices. She said that she can tolerate cumin, which she loves and it goes in most of the things that she cooks.

271. Also in the course of cross-examination, she was taken to a small number of Facebook posts. They included a post from Christmas Eve 2019 that made reference to cooking lamb and making a trifle. She said that it was Christmas Eve, her family were with her and both her sons are good cooks. She made the trifle. Her family cooked the lamb in the oven. She said that she no longer eats meat. There were 3 posts from 2019 and 2020 that made reference to “curry”, although the nature of the spice in the curry was not stated. It was put to her that the posts gave the impression that she had made the curry and she said that “what you put on Facebook isn’t 100%... it’s Facebook”. She said that she was not the person who had actually made the curry. She said that either Anna or Janette would have made it. There was a post from 2021 that referred to hollandaise with tarragon (a herb rather than a spice) and it was put to her that she had made it. She could not remember. There was another post in 2021 that referred to a breakfast that included yoghurt sprinkled with smoked paprika. She was asked if she had made it and again she could not remember. There was a post from 2022 that referred to supper being sticky chilli ribs and tartiflette. She said that Annie had cooked it and she had had the tartiflette because she does not eat meat.
272. My analysis of this evidence is as follows. It is clear that pre-laryngectomy the Claimant found considerable enjoyment in food. She enjoyed entertaining and cooking for large groups. She was an accomplished cook with a particular enthusiasm for Indian food and for cooking with very strong spices from scratch.
273. Her evidence is that post-laryngectomy she has lost a good deal of her enjoyment of food. It is uncontroversial that a laryngectomy means there is no airflow through the nose and as a result there is a loss of sense of smell, with an inevitable consequential effect upon taste and enjoyment of food. In my judgement the handful of Facebook posts expressing enthusiasm for meals are simply indicative of her generally upbeat and positive approach to Facebook. They do not mean that she has regained her sense of smell, taste or previous levels of enjoyment of food.
274. Her evidence is that post-laryngectomy she no longer cooks for large groups. This is confirmed by Anna Crowley and there is no evidence in the Facebook posts of her doing so.
275. Her evidence is that post-laryngectomy her ability to cook has been very significantly curtailed and in particular she avoids things like strong spices that will irritate her airway and cause her to cough, which is unpleasant in itself but when it occurs violently, it risks dislodging her voice valve. Her evidence in relation to this is consistent with the expert evidence that exposure to irritants such as cooking fumes will cause her to cough. It is also consistent with the evidence of Anna Crowley and the reported evidence of Dayne Cullen, both of whose evidence I have already considered in relation to other aspects of the case and whom I consider to be honest witnesses. I also bear in mind what I consider to be her honest evidence about other aspects of cooking and food, namely her evidence of her reduced sense of smell/taste and consequential loss of enjoyment of food and her evidence about not cooking for large groups. So far as the Facebook posts are concerned, I accept that some of them appear, on their face, to be inconsistent with the Claimant’s evidence in relation to cooking with spices. However I also accept that her Facebook posts are not solemn declarations and in my view I

should be very cautious about approaching them as such. It seems to me that for a person like the Claimant, whose Facebook posts are generally upbeat and positive and who was previously an accomplished cook, there is a strong temptation to continue to present such a picture on Facebook, even if the reality is less positive. I bear in mind my impression of her evidence when she was cross-examined about these posts. I found her to be a convincing witness. Having carefully weighed all these factors, to the extent that there is a discrepancy between the Claimant's Facebook posts and the Claimant's evidence given on oath at trial, I prefer and accept the latter.

276. Looking at this evidence in the round, it is my judgement that the Facebook posts do not establish that she has been dishonest in relation to cooking and food.

Conclusions on the Defendant's allegations of fundamental dishonesty

277. For the reasons set out above, I reject the allegations of fundamental dishonesty.

QUANTIFICATION OF THE OUTSTANDING HEADS OF CLAIM

278. I turn now to quantification of the outstanding heads of claim.

Quantification of the past and future care claims

279. I refer, without repetition, to my findings of fact set out above. In addition, I have considered the Claimant's own evidence in relation to her future care, which is contained in her witness statement dated 23 May 2023. In that statement she said that she has been lucky so far to have had the support of her son Dayne and to have had the continuity of care that Anna Crowley has provided. However she makes clear that her son will want to move out and have a life of his own and that Anna Crowley has indicated that she would like to retire in the next year or so. She expresses her concerns about finding replacement carers and how she has come around to the idea that in future, she will need to hand over responsibility for sourcing her carers to an agency. She goes on to say that she understands that she will also need a case manager to manage the transition and help her to find and appoint an agency. She did not elaborate on this at trial.

280. I now turn to the evidence of the care experts.

281. Ms Howison's report is dated June 2023. In that report, she assessed the past gratuitous care that had been provided to the Claimant by her family and friends, applying an hourly rate to the number of hours care provided. The detail of the calculation is set out in her report. Since Mrs Howison was assessing gratuitous care, she did not include care that was funded by first the local authority and then the NHS, and her assessment of past gratuitous care ended when the Claimant began to receive 24 hour funded care in September 2021. Approaching matters in this way she arrived at an overall undiscounted figure for past gratuitous care of £267,675. So far as future care was concerned, she considered that the most appropriate way of providing 24 hour care was managed commercial care provided by a care agency. To that end she approached Prestige Nursing and Care Agency and following discussion with them, she was advised that the Claimant would require a level 2 carer with advanced skills and she was provided with hourly rates. From these she calculated an annual cost of £339,487, with

additional costs for bank holidays and also for case management. The Claimant's Schedule of Loss adopted Mrs Howison's figures.

282. Ms Palmer's report is dated October 2023. She considered that fewer hours had been provided and she considered that a lower hourly rate was appropriate. Again the detail of the calculation is set out in her report, but the main point of disagreement was in the level of care that the Claimant needed post-laryngectomy. Ms Palmer's overall undiscounted figure for past gratuitous care was £77,355.42. The Defendant's Counter-Schedule did not wholly adopt Ms Palmer's figures. An undiscounted figure of £20,000 was offered in respect of gratuitous care up to August 2017, which corresponded to her figures. Thereafter, instead of her figure of c£57,000, the Defendant offered a further undiscounted £20,000 up to March 2018 and nothing at all thereafter. So far as future care was concerned, Ms Palmer considered that a 6-month period of rehabilitation followed by a small number of support worker hours each week, and provision for up to 4 weeks/year of more intensive care during periods of illness, would suffice.
283. Mrs Howison and Ms Palmer prepared a joint statement dated 1 February 2024. One of the questions they were asked was to value future care on the basis that the court finds that the Claimant reasonably needs 24 hour care. This had been the basis for Mrs Howison's initial report. In the joint statement she reiterated her figure of £339,487pa for managed private agency care. She also provided an alternative cost for privately engaged care, which produced an annual figure of £238,909pa. Ms Palmer expressed the view that if this were the court's determination, then she considered that care could be provided through live-in care. She said that Bluebird Care had advised that costs would range between £78,000 and £98,800pa depending upon assessment. All that said, by the time of this joint statement the updated medical records had been received, in which the Claimant was described as a 'self-changer'. As a result of this development, in that joint statement, Mrs Howison substantially revised her opinion in relation to past and future care needs, effectively agreeing with much of Ms Palmer's original assessment. Consequent upon Mrs Howison's change of opinion, and changes in the opinions of other experts based on the SLT records, the Claimant amended her Schedule of Loss, bringing her past and future care claims into line with Mrs Howison's revised opinion and Ms Palmer's original assessment. She reduced her claim for past care to £63,750 and her future care claim to £159,939 (as per the Defendant's Counter-Schedule).
284. There then came the clarification of the meaning of self-changer. Mrs Howison provided a further report dated 23 February 2024. In that report she reviewed her position on future care. She considered that a reasonable alternative to visiting agency care would be the provision of a live-in carer, provided by an agency at an annual cost of between £88,638 and £94,040. This cost reflected London weighting and the fact that most agencies will apply an uplift when clinical care is required. Consequent upon Mrs Howison's further change of opinion, the Claimant re-amended her Schedule of Loss, reinstating her future care claim, albeit based on the cost of a live-in carer rather than visiting agency care.
285. On the same day, 23 February 2024, Ms Palmer prepared a further report. She had been provided with the supplemental letters of other experts who had seen the updated clinical records and who had expressed concerns that, contrary to what they had been told, the Claimant was a 'self-changer'. Ms Palmer, who was already sceptical about the Claimant, was therefore provided with the sceptical views of others experts, which

reinforced her own. She was also provided with the Facebook posts and the surveillance footage. Her views became further entrenched. She withdrew her recommendation of a period of rehabilitation.

286. The trial then began and the care experts were present in court for most of the evidence. During the trial and in the period when the trial adjourned part-heard, there were significant developments in the ENT and SLT expert evidence, which I have already considered earlier in this judgment. On 17 June 2024 Mrs Howison produced a further report. In that report she said that she considered the acceptance of Ms Palmer's figure for past care significantly undervalued the care that Dayne Cullen had provided. She provided figures for alternative models of future care, but she reaffirmed her view that 24 hour live-in care, with the carer resting at night but available to respond to urgent need, remained her preferred option.
287. The ENT and SLT experts gave evidence on 21 June 2024, following which the trial adjourned to 2 July 2024 for the care experts to give evidence. In the intervening period there were two further joint statements from them (the Claimant and the Defendant having been unable to agree a single agenda). In the joint statements, Mrs Howison withdrew her recommendation for a live-in carer based on practical difficulties in sourcing suitable carers. She had approached two agencies (Helping Hands and Home Instead) who had been unable to offer live-in carers. She stated that her preferred option was a mid-point between (a) the Claimant's current CHC budget of £178,361.52pa which Mrs Howison said represented the cost of directly employing her current team of carers who had been recruited from a pool of family and friends and who were not paid the full commercial rate, and (b) the cost of directly employing a team of carers at commercial rates which she assessed at £238,909.07pa. This produced a mid-point figure of £208,635.55pa. In addition, this model required a case manager, with set up costs of between £18,750 and £25,000, plus annual case management costs of £15,956.25pa. For want of a better description, I shall refer to this as 'the mid-point option'. Ms Palmer did not agree with the agreed SLT evidence and she stated that the ENT experts were not recommending 24 hour care before the age of 75 (this was not an accurate statement of the ENT evidence). She said that she continued to recommend rehabilitation as her preferred option (in fact this was a shift in opinion from her report of 23 February 2024 where she withdrew the recommendation for rehabilitation), but if the court determined that the Claimant required live-in care, she recommended a live-in carer at a cost of £96,680pa.
288. When the care experts gave evidence at trial on 2 July 2024, they were cross-examined about their recommendations.
289. Mrs Howison was asked about her experience in the establishing care packages and she accepted that she had never actually designed, constructed or managed a care package in the community. She was asked about her changes of opinion and in particular the shift from live-in carer to direct employment of carers in the report of 21 June 2024. She said that she had become concerned about availability and turn-over of live-in carers and she repeated what she had said about contacting two agencies. She was asked if she had gone back to Prestige, the agency she had relied upon for the costings in her original report, and she said that she had not. She said she had only ever used them for visiting commercial care. She said that for her case management figures, not being a case manager herself, she had relied on a case management company.

290. Ms Palmer was asked about why, in her report and subsequently, she had not mentioned the views of those experts who were agreed that the Claimant needed 24 hour care. Her answer was that firstly she had mentioned Ms Heathcote's contrary view and secondly she was of the view that what was needed was a period of intensive rehabilitation, neither of which seemed to explain the omission in the reports. In any event, she stuck to her opinion that rehabilitation was what was needed. When asked about emergencies, she said there are options like Telecare where the Claimant would wear something round her wrist or neck and press a button if she really could not manage her situation at any time. She said that Telecare have a response time of about 20 minutes and if they felt an ambulance was needed, they would call one. This suggestion was not in her report and had not been put to any of the ENT or SLT experts. I did not find these aspects of her evidence to be persuasive. She was asked about some of her comments on the evidence and on inconsistencies. Again I did not find these to be particularly helpful, and as she had to concede, they are ultimately matters for me.
291. Where I found Ms Palmer's evidence much more helpful and authoritative was in relation to the model for future care and in particular the live-in carer option. This was not her preferred option and she was not recommending it, favouring, as I have said, intensive rehabilitation. But if the court determined that 24 hour care was required, then she recommended a live-in carer. She said that she had quite a lot of experience of putting these packages in place, not for a laryngectomy patient, but for the elderly and for people with conditions such as dementia and traumatic brain injury. She described how the arrangement would normally work. The client would be involved in the recruitment process, to ensure compatibility. Normally carers would be resident for 2 weeks and then take 2 weeks off, with this cycle repeating over the long term. However it is flexible and sometimes it would be a longer period on and then off. She said that it would be the same small group of carers who would provide this rotating care, usually 2, but sometimes 3 carers, and so the client would get to know them well. She said that because the carers are supplied by an agency, there is the back-up of the agency in case of illness or similar. She had not experienced problems recruiting live-in carers and she had not experienced the problems with turnover of staff that Mrs Howison had described. She had spoken to four agencies about the provision of a live-in carer. These agencies had said that they do not have a problem recruiting or retaining staff and Ms Palmer was not aware of other agencies experiencing these difficulties. The agencies she approached described being able to provide live-in care within 2-3 weeks. She said that of the four that she contacted, three could not provide live-in care in this particular case simply because they were not nursing agencies. The Claimant's care has a respiratory component and the CQC stipulate that in those circumstances, only nursing agencies are permitted to provide the care because they have nursing support available to support the carers. The fourth agency, which was Prestige, and which is a nursing agency, was able to provide a live-in carer. So far as training for the carers is concerned, there is provision within the claim for specialist SLT training and Prestige would provide any other training that was required. Prestige had confirmed the availability of live-in carers to Ms Palmer in the previous week and the figure of £96,680 was up-to-date. She said that Prestige is a reputable agency and she has used them in the past and never had a problem with them, but there are other reputable agencies in the market in addition to the ones she had contacted and rates are reasonably consistent across agencies. She said that so far as holidays are concerned, the carer would accompany the client on holiday to provide care. The client would need to meet the associated costs of the carer travelling. She said that her experience of setting up live-in care packages

extended over 8 or 9 years and there had only been one case where she had had any difficulty, which was due to the behaviour of the client who had dementia, but they had nevertheless managed to find a way of working that suited the client. She said that on the whole the carers are very good, they establish good working relationships with the individual and with their family and friends and it is a good package of care.

292. Picking up Ms Palmer's evidence that the live-in model envisages the carer accompanying the Claimant on holiday, with the Claimant bearing the carer's costs of doing so, it follows that if this model is adopted, provision will have to be made for the carer's holiday costs. I am satisfied that the Claimant will travel with her carer in future, at least to the extent of two trips per year, rather than relying on the goodwill of friends and off-duty carers as she has so far. It seems to me that similar provision is necessary whichever model is adopted for future care. Mrs Howison provides figures for holiday costs. If two holidays/trips are taken each year with her carer, which is broadly consistent with the Claimant's travel arrangements in the last few years, that would add £2,200 + £2,300 = £4,500pa.
293. At the close of the evidence on 2 July 2024, the Claimant was permitted to re-amended her Schedule of Loss to adopt Mrs Howison's mid-point option.
294. Before I turn to my conclusions on care, I shall deal briefly with the way in which the pleaded value of the claim has fluctuated during the course of the litigation. The Defendant criticises the Claimant for this. However, as I have found, the Claimant's evidence has not changed. I have found that she has given a consistent and honest account of the effect of her injuries upon her. What has changed during the course of the litigation has been Mrs Howison's opinion. At each stage, the Claimant has adopted Mrs Howison's opinion, even when it was plainly to her disadvantage to do so. It seems to me that whilst the fluctuating valuations expose Mrs Howison's lack of practical experience in setting up care packages in the community, and undermine the authority of her final opinion, they do not indicate that the Claimant has been dishonest.
295. I turn now to my conclusions.

Past care

296. So far as past care is concerned, I accept the evidence of the Claimant and her son Dayne that since her discharge from hospital on 18 August 2018, she has received 24 hour care. This has not been in the form of 24 hour hands-on care, but in the form of someone being in attendance and providing care as and when required. This finding results in a figure for past care that is well in excess of the sum of £63,750 that is claimed. I come to this conclusion as follows. If I look at Mrs Howison's original report and her figures for care in the period between discharge from hospital and September 2021 (there is a substantial figure for care prior to this date, but there are issues over the extent of the care that would have been required in any event and so I put that to one side for present illustrative purposes), they come to a total of c£211,000. There is an issue over hourly rates, with Ms Palmer's proposed hourly rates being less than those selected by Mrs Howison. The difference is generally less than 10%. If I make (generous) allowance for the dispute over hourly rates and reduce the figure of c£211,000 by 10%, it reduces to c£190,000. If I then discount this figure by one third to reflect gratuitous provision, it reduces to c£127,000. I do not reduce it further to reflect those holidays taken during the period on the basis that, whilst the gratuitous

care on holiday was not being provided by Dayne Cullen, it was being provided by those friends and off-duty carers who accompanied the Claimant on those holidays and on whose behalf the Claimant is entitled to make a claim. However I do reduce the care figure by the amount of carer's allowance received in this period, which at £67.60/week for approximately 3 years reduces the figure to c£116,000. Even making all these allowances, the figure is still very substantially in excess of what is claimed. That being so, and the Claimant having expressly chosen to maintain her figure of £63,750 in the knowledge that it is likely to be an underestimate, I make the award in full. I therefore assess past gratuitous care at £63,750.

Interest

297. I invite the parties to agree an up-to-date figure for interest on general damages and past losses.

Future care, case management and carers' holiday costs

298. So far as future care is concerned, I have found that the Claimant requires 24 hour care. This is not 24 hour hands-on care, but her care needs are intermittent and unpredictable and when she needs assistance, she needs to have someone on hand to assist her. This translates into 24 hour care. The question is how this is to be provided. The claim is advanced as a claim for a lump sum award and Mr Hough reiterated in closing that that is what is claimed, rather than any form of periodical payment.
299. In closing, the Defendant makes the following concession: that if the court finds the Claimant to be honest and rejects the allegations of fundamental dishonesty, the Defendant concedes that future care should be provided on the basis of a live-in carer. This is described as a concession, in the sense that it removes from consideration Ms Palmer's preferred option of rehabilitation followed by modest levels of care from a support worker, but it does not remove the need for me to decide on the appropriate model for future care as between the remaining options.
300. The remaining options are (a) the mid-point option, and (b) the live-in option.
301. The live-in option had been Mrs Howison's preferred option until only a few days before she gave evidence. It had always been Ms Palmer's recommendation in the event that the court considered that 24 hour care was necessary. In my view, this consensus was justified. This option satisfies the Claimant's wish to relinquish responsibility for recruitment and management of carers and hands that over to an agency. It satisfies her wish that there be continuity of care and that she will always have someone to assist her. The model involves 2, maybe 3, regular carers living-in, in rotation, but with the resources of the agency to fill gaps in care should they arise. It provides the opportunity for the Claimant to be involved in the selection of carers, for her to have regular carers who know her and her care needs well and it allows her to develop the sort of close personal connection to her carers that she has greatly valued in her current arrangements. It seems to me that one of the great strengths of this model is that it is relatively simple in its structure and in its delivery, which would tend to increase its reliability, and it is underpinned by the resources of the agency and is not therefore dependent on a single individual such as a case manager. The mid-point model suffers from the reverse, namely it is a significantly more complicated arrangement, involving a team of carers with much less personal loyalty to the

Claimant, and with a correspondingly increased risk of gaps appearing and continuity of care being lost. It would cost very significantly more and I consider that it would deliver a less secure result.

302. As for the reasons why Mrs Howison abandoned the live-in option in favour of the mid-point option, I did not find them persuasive.
- i) The first was the availability of live-in carers. She had spoken to an independent care consultant and telephoned two agencies, Helping Hands and Home Instead, who had been unable to provide live-in care. It seems to me that this was a fairly cursory survey of the market. In fact, as Ms Palmer explained and I accept, Helping Hands is not a nursing agency and no longer provides a respiratory service, so they would not have been able to provide a live-in carer in any event. The evidence did not reveal whether Home Instead was a nursing agency or not. More significantly, Ms Palmer was able to source a live-in carer simply by telephoning Prestige, the very agency that Mrs Howison had used when preparing her original report but which she did not contact when reconsidering her recommendations for the joint statement. Ms Palmer, who has a great deal of experience of setting up live-in carer arrangements, said, and I accept, that there are other reputable providers in the market. She did not envisage any difficulty finding a reputable provider of live-in care. In short, I prefer and accept Ms Palmer's evidence as to the availability of the live-in option.
 - ii) The second reason Mrs Howison gave for abandoning the live-in option was based on what she considered to be the necessary skill level of the Claimant's carers. I remind myself that the vast majority of laryngectomy patients who need on-going care receive it quite satisfactorily from their partner or another family member, i.e. from someone who has become their carer by chance rather than because they were already a specialist carer. I further remind myself that most of the Claimant's current carers did not start out as specialist carers, have had no formal training (they have been shown/told what is needed by Dayne Cullen, Anna Crowley and the Claimant herself) and only Dayne Cullen and Anna Crowley have received any sort of training from the Claimant's SLTs. Despite this, they have successfully learnt how to care for the Claimant and they have successfully provided her with the care that she needs. Lastly I remind myself of Anna Crowley's evidence that what are required are "confidence, a steady hand, good eyesight and a reliable torch". In my view there is no reason to suppose that individuals who already work as full-time carers would not be able to acquire such further skills as are required to look after the Claimant, particularly in circumstances where they are supported by a nursing care agency as opposed to a general care agency, and particularly where there is specific provision within the award of damages for SLT training.
 - iii) Mrs Howison's third reason was that she thought that the Claimant did not want someone living in her home 24/7. In fact there was no evidence to this effect, as Mrs Howison had to concede. On the contrary, live-in care was the case that the Claimant was specifically advancing from 29 February 2024, the date of her Re-Amended Schedule of Loss, until 27 June 2024, the date of her Re-Re-Amended Schedule of Loss. It was the case that she was advancing when she gave evidence at trial and there was no indication in her evidence that she was not content with such a proposal. The final amendment came about as a result of

Mrs Howison's change of opinion, not as a result of any further evidence from the Claimant. I observe that whilst I am sure the Claimant would prefer not to be dependent on care and to live independently, the reality of 24 hour care is that she has been, and will be in future, sharing her home 24/7 with her carer.

303. For all these reasons, my judgement is that the model that best meets the Claimant's reasonable future care needs is the live-in option. I assess the multiplicand for the future care claim at £96,680. The multiplier is agreed at 13.3. This produces an award of £1,285,844.
304. In view of my conclusion on future care, the claim for case management costs falls away.
305. So far as the claim for carers' future holiday costs is concerned, the rationale for this head of claim is to enable the Claimant's carer to accompany her on holiday. I assess the multiplicand at £4,500. I consider that she will continue to travel for as long as she possibly can, but there will eventually come a time when advancing age precludes her from doing so. I reflect this in a reduction of the full life multiplier from 13.3 to 11 for this head of claim. This produces an award of £49,500.

Quantification of future psychological treatment costs

306. There is a claim for the cost of future psychological therapy. The expert psychologists are agreed that psychological therapy is needed, in the form of Cognitive Behavioural Therapy and/or Acceptance and Commitment Therapy. They are agreed that the cost per session is £125. They are agreed that therapy is required now, but they differ as to the number of sessions required. Dr Carstairs on behalf of the Claimant recommends 30-40 sessions. Dr McGillion on behalf of the Defendant recommends 12-14 sessions. They are further agreed that future deterioration of the Claimant's ability to communicate will necessitate further sessions. Dr Carstairs recommends 20-25, Dr McGillion recommends 12-14 further sessions. Adopting the mid-point of each range, Dr Carstairs' recommendations produce a total figure of £7,187.50, which is what has been claimed. A similar approach to Dr McGillion's recommendations produces a figure of £3,250, although the counter-schedule only offers £1,625. This is said to include a contingency for future needs, although it is not apparent that any amount has been included in respect of any such contingency.
307. I have read the written reports of the experts. However I have not heard oral evidence from either of the experts, nor did either party address me on this issue in closing. I accept that immediate therapy is required. It is now 7 years post-laryngectomy and the need for this therapy remains. I think it is more likely than not that such persisting symptoms will require a longer period of treatment than that recommended by Dr McGillion and I consider a figure at the lower end of Dr Carstairs' range to be reasonable. This produces a figure of $£125 \times 30 = £3,750$. So far as future therapy is concerned, I consider that, on balance, future deterioration in the Claimant's ability to communicate will have a very significant impact upon the Claimant and require more sessions than that recommended by Dr McGillion. Again I adopt a figure at the lower end of Dr Carstairs' range as reasonable, to which I apply a modest discount to reflect accelerated receipt. This produces a figure of $£125 \times 20 \times 0.9 = £2,250$. This produces an overall award of £6,000. I then stand back and consider whether this broadly accords with what I would have awarded on a more broad-brush lump sum basis and I am

satisfied that it does. In all the circumstances, therefore, I award £6,000 for future psychological therapy.

Quantification of future equipment costs

308. There is claim for the cost of speech and language therapy equipment in future in the sum of £37,305.18. It has two broad components. The first is a claim for 'laryngectomy equipment' in the sum of £30,543.58. This is agreed in full. The second is a claim for the cost of an iPad Pro, together with accessories including software providing a text-to-speech facility. The claim is based on replacement intervals of 3 years. In total it amounts to £6,761.60. It is denied on the basis that the Claimant would have been likely to have had similar in any event. In fact in an effort to narrow issues, the Claimant has offered a compromise figure in her re-re-amended Schedule of Loss, but the issue remains unresolved.
309. I approach the issue on the basis that I must be satisfied firstly that the item is reasonably required as a result of the Claimant's injuries. I am satisfied that text-to-speech software is something that will be reasonably required and that a computer, tablet or similar is necessary for the software to be used. I must then be satisfied that the item is something that the Claimant would not have purchased for herself in any event. In my view, an iPad, or at least a tablet, is a commonplace item which the Claimant is likely to have purchased for herself in any event. On that ground, I would disallow the claim for an iPad. However I am satisfied that text-to-speech software is not something that the Claimant would have purchased for herself in any event and therefore, in respect of that part of the claim, the only remaining question is whether she will use it. It is anticipated that her voice will deteriorate in future and, as that happens, the motivation to find and use other methods of communication will increase. I am satisfied that there will come a time when she will use such software. I therefore allow the claim for the cost of the software in the sum of £159.99, discounted by 10% for accelerated receipt, producing a figure of £144 to be added to the agreed figure of £30,543.58, making a total of £30,687.58.
310. There is also a claim for two items of physiotherapy equipment. The first is a pelvic floor trainer in the sum of £150. The Claimant suffers from stress incontinence. The issue is whether this has been caused by her laryngectomy or whether she would have suffered from it in any event. On the one hand her laryngectomy has led to the loss of humidification, more viscous secretions and a greater need to cough. On the other hand, absent her laryngectomy she would still have suffered from COPD causing her to cough and her cough would have been much stronger than it is now, because she would have been able to cough against resistance. Absent further expert evidence on these issues, I am unable to take this analysis any further and I cannot say, on the balance of probabilities, that her stress incontinence has been caused by her laryngectomy or that she would not have suffered from it in any event. I therefore disallow this head of claim. The second item of physiotherapy equipment is a claim for TheraBands in the sum of £25 to enable her to exercise her right shoulder, which is severely dysfunctional as a result of the right accessory nerve palsy. This item is agreed.
311. For these reasons, I award $£30,687.58 + £25.00 = £30,712.58$ in respect of future equipment.

Double recovery

312. Lastly, there is the issue of double recovery. I have no reason to doubt the sincerity of the Claimant's wish to move away from her current dependence on NHS funded care and to move to a situation in which she is able to pay for her own care. The award of damages for future care based on £96,680pa is intended to provide for such an outcome. At the same time, the Claimant is currently in receipt of a Personal Health Budget of c£178,000pa which pays for her current care arrangements. Her entitlement to this funding is based on need, which is reassessed annually. There is no reason to think that her care needs will change in future such that she will become ineligible for this funding and certainly it is my judgement that she will continue to need full time care for life. An award of damages will not affect her entitlement to this funding since it is not means-tested.
313. It is in these circumstances that the Defendant rightly points out that there is a risk of double recovery. In written closing submissions, the Defendant made a number of proposals as to how double recovery might be avoided. Closing submissions had been simultaneously exchanged very shortly before the date for oral submissions and as a result, the Claimant was not in a position to respond on 19 July 2024 beyond acknowledging that double recovery should be avoided. Mr Hough expressed the view that the approach that the parties take may depend to some extent on my judgment, but that the parties would be able to agree a form of words for inclusion in the final order. That was how matters were left. I therefore invite the parties to draw up a final order that reflects my judgment and incorporates a reasonable safeguard against double recovery.