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IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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QUEEN'S BENCH DIVISION

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BETWEEN:

ANTHONY DEERY
AS PERSONAL REPRESENTATIVE OF THE ESTATE OF MARGARET DEERY (DECEASED)

Plaintiff

and

MINISTRY OF DEFENCE

Defendant

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McALINDEN J

Introduction

[1] Margaret Deery ("the deceased"), was born on 9 August 1933, and died at the age of 54 on 26 January 1988, with the cause of death being stated to be myocardial infarction. Her son who is the personal representative of the deceased's estate, claims damages against the defendant in respect of injuries suffered by the deceased when, at the age of 38 years, she was shot in the left thigh by a high velocity round fired by a soldier while the deceased was present in Chamberlain Street, Londonderry, on the afternoon of Sunday 30 January 1972. The soldier (identified as Lance Corporal V at the Saville Inquiry) using a SLR rifle, fired from a location close to the Rossville Flats. The Saville Inquiry found that Lance Corporal V shot the deceased from relatively close range. The Saville Inquiry noted that the justification consistently offered by Lance Corporal V was that he fired one aimed shot at a male petrol bomber and that he hit his intended target. This account was comprehensively rejected by Lord Saville. The Inquiry concluded that Lance Corporal V had given knowingly false evidence to the Widgery Inquiry and that the deceased was an entirely innocent victim who, without justification, was shot by Lance Corporal V on the day in question.

[2] The deceased had been recently widowed at the time of the shooting. Her husband had died after a prolonged battle with cancer some four months earlier. The deceased had been left caring for 14 children, six sons and eight daughters, aged between 16 years and eight months. At the time of Bloody Sunday, the family lived at 7 Swilly Gardens in the Creggan estate. Shortly after Bloody Sunday, while the deceased was still an inpatient in hospital, the family moved to 31 Westway also in the Creggan estate. The deceased was discharged from hospital to this address. Her bedroom was downstairs but the only toilet in the house was upstairs. The family then moved to 82 Creggan Heights in the autumn of 1972 to be closer to the deceased's sister. In that house all the bedrooms were upstairs but the only toilet/bathroom was downstairs. The relevance of the deceased's living arrangements will become apparent when I come to discuss her level of disability and her care needs at a later stage in this judgment.

[3] Returning to the immediate circumstances surrounding the shooting of the deceased, it is undoubtedly the case that she was shot at close range while she was facing the soldier who shot her. The high velocity round entered the front of her left thigh, shattering her left femur and causing severe soft tissue damage before exiting via a large exit wound to the rear of the left thigh. The deceased was carried to a house in the immediate vicinity (33 Chamberlain Street) where she was treated by a member of the Knights of Malta. While the deceased was receiving emergency first aid in 33 Chamberlain Street, soldiers entered this address and directed abusive comments to the deceased. It is alleged that one soldier said: "Let the whore bleed to death." Lord Saville looked into this allegation and reached the following finding:

> "…looking at the evidence as a whole, we are satisfied that some of the arresting soldiers directed foul language at the civilians sheltering in 33 Chamberlain Street and we consider that it is probable that abusive remarks of the nature described above were either directed towards or about the seriously wounded Margaret Deery and Michael Bridge. Some of the soldiers' remarks may have been in response to language used by some civilians. In the context of what happened on Bloody Sunday, such an exchange of bad language is of little consequence, but we can find no excuse at all for the abusive remarks directed towards or about the wounded Margaret Deery and Michael Bridge."

[4] The deceased was taken by ambulance from 33 Chamberlain Street to Altnagelvin Area Hospital. In addition to the obvious signs of severe injury to her left lower limb, the deceased was found to be suffering from hypovolaemic shock due to severe blood loss. She required resuscitation and blood transfusions. In all, the deceased was given six units of what turned out to be incompatible blood. As a result, she developed kidney failure and was transferred to the Renal Department of

the Belfast City Hospital on 1 February 1972. The deceased had suffered a grossly comminuted fracture of the femur. There was severe damage to the thigh musculature and the sciatic nerve was also severely damaged. Surgical reduction of the fracture was carried out and the extensive wound was debrided. The sciatic nerve could not be repaired. The wound was packed and dressed and the thigh and knee were encased in a long plaster of Paris cast. A Steinmann's pin was inserted into the left tibia and a Thomas splint was applied to the left leg. Post-operatively sensation and movement were noted to be absent in the left foot.

[5] Following the transfer of the Belfast City Hospital, the deceased became progressively more anaemic due to continued destruction of the transfused incompatible blood by her immune system. Further blood transfusions were required. However, the blood chemistry results revealed progressive derangement resulting from continuing renal failure and peritoneal dialysis was commenced between 5 February 1972 and 12 February 1972. The deceased continued to be very ill and toxic with severe pyrexia up until 15 February 1972. It became apparent that she had developed a significant wound infection which was treated by means of intravenous antibiotics. She required further blood transfusions. The wound was dressed under anaesthetic on 16 February 1972. The deceased's renal condition improved somewhat and she was discharged from the Belfast City Hospital back to Altnagelvin Area Hospital on 3 March 1972.

[6] The deceased was taken back to theatre on 7 March 1972 for examination of the fracture and wound under general anaesthetic. The wound was noted to be infected and it was cleaned and dressed. On that occasion, a traction pin was inserted into the os calcis. A further examination under general anaesthetic took place on 21 March 1972. An x-ray performed on that occasion revealed the continued presence of a fracture of the distal shaft of the left femur with moderate lateral displacement and foreshortening of the distal fragments. No improvement in the position of the fracture could be effected by manipulation under general anaesthetic on that date. Further x-rays taken on 13 April 1972 revealed poor position of the fracture fragments with callus formation. The lower fragment was displaced backwards and a calliper was ordered at this point. A split skin graft was applied to the granulation area on the back of the left thigh on 18 April 1972. The donor site was the posterior aspect of the right thigh. A discharging sinus was noted to be present on the left thigh on 19 April 1972. By 22 May 1972, the grafted area on the back of the left thigh was noted to have largely healed although there was still some discharge from the sinus. Cultures from the discharge revealed the presence of ongoing infection. The deceased was mobilising to a limited extent with the aid of a calliper. Antibiotic therapy was tailored to deal with a coliform infection and daily dressings were applied to the wound. The deceased developed a pressure sore on her left heel. The calliper was removed and she was encouraged to commence mobilisation, non-weight bearing. The deceased was eventually discharged home from inpatient care on 29 May 1972. At that stage she was still non-weightbearing and a photograph taken at that time shows her with her left foot dressed, seated in a

wheelchair with crutches beside her. Initially, she had to return to the hospital on alternative days for dressings.

[7] The deceased had limited contact with her children when she was in hospital in Belfast. A local priest, Father O'Gara, drove some of the older children up to see their mother during this period. When the deceased was transferred back to Altnagelvin, the older children took the younger children up to see their mother on a daily basis. The deceased was subject to regular orthopaedic review following her discharge from inpatient care. There is a reference to "true sciatic nerve palsy" following a review on 23 August 1972. There was no control of foot movement in any direction. There was no movement in the toes of the left foot. Left knee flexion was limited to 45 degrees. Extension was full. By February 1973, the deceased was noted to be managing well with crutches. She had no motor function in her foot or ankle. There was limited recovery of sensation in her lower leg but this did not extend as far as the foot. There was an ulcer present on the great toe which required dressings.

[8] By June 1973, some further recovery of sensation in the lower limb was noted. However, there was no useful movement in the foot or ankle. She was referred for fitting of a new calliper. By March 1974, the deceased was described as mobilising reasonably well in long boots with the help of a stick. She had developed an abscess on the posterior aspect of the thigh and when reviewed, the presence of a small discharging sinus was noted. Motor function in the foot and ankle was largely absent. Sensation had improved somewhat but was still absent from the sole of the foot and heel. There was a pressure sore on the lateral side of the ankle. The deceased was noted to have a fixed equinus deformity of the left foot. By January 1975, the deceased was noted to be still using a calliper and still had some ulceration on the lateral aspect of the left ankle which required dressing. By February 1976, the fixed equinus deformity of the left foot was noted to be in the region of 30 degrees. The deceased was admitted on 12 February 1976 for lengthening of her Achilles tendon and division of the posterior capsule of the ankle joint. She was discharged in a short-leg cast, mobilising on crutches.

[9] The deceased was reviewed following this surgery on 13 October 1976. By that stage, she was noted to be pleased with the results of surgery in that the foot was sitting in a more neutral position with only slight plantar flexion. The deceased still required a support in order to mobilise. The last reference in the available notes and records to any relevant treatment for left foot problems is contained in a letter from Mr Panesar, FRCS, to the deceased's General Practitioner dated 9 November 1987. Mr Panesar, FRCS, a Consultant General Surgeon based in Altnagelvin, carried out a domiciliary visit on that occasion which is indeed unusual. He noted the presence of a neuropathic left foot. There was a pressure sore on the lateral aspect of the left foot. A further review was recommended and the possibility of skin grafting was mooted.

[10] Going back in time, there is a hospital discharge note in the available notes and records dated 2 March 1973. This relates to the admission of the deceased to Altnagelvin on 10 February 1973 with a 6 hour history of severe backpain, radiating into the abdomen. On examination, there was tenderness in the left renal angle and along the line of the left ureter. There was guarding present in the left side of the abdomen. The deceased was feeling cold and was shivering but had a temperature. An emergency IVP revealed definite signs of obstruction of the left ureter. The deceased improved with conservative management (antibiotics and pain relief) and was discharged on 13 February 1973.

[11] Finally, there is a letter from the deceased's General Practitioner dated 28 September 2018. Dr Anne Doherty prepared this letter for the purposes of this claim based on her personal recollection of Mrs Deery; the deceased's General Practitioner's Notes and Records having long since been destroyed. Dr Doherty joined the practice in 1984 and attended Mrs Deery until her death in January 1988. She recalls that the deceased had significant physical and mental health needs. She recalls that the deceased received regular home visits due to her mobility deficits and this is clearly demonstrated by the fact that Mr Panesar, FRCS, carried out a home visit in November 1987. Dr Doherty described the deceased in the following terms:

> "Peggy was a young woman who depended on her family for all aspects of her adult daily living needs. I recall she lived mostly in her bedroom; her bed was in the corner of the room. She would have been prone to low moods and depression.
>
> I was asked to comment if Mrs Deery would walk in the street or go to the shops – I never saw Mrs Deery function at this level or recall her leave her bedroom or family home.
>
> I am unable to be concise or recollect anything in relation to renal problems. I could not be specific about what medication she was on at the time but I would be happy to comment that she functioned at a low level in response to her trauma and psychological issues. I feel that it would be likely that she was on medication for her mood as this is what would have been done reasonably at the time."

[12] Going back to the day of the shooting, the deceased's daughter, Helen Deery who was then aged 13 years, gave evidence before me on 4 March 2021. She recalled how she had accompanied her mother to the civil rights march but had become separated from her at an early stage. She did not witness her mother being shot and

only became aware of what had occurred later that evening. I will return to Helen Deery's evidence when I come to consider the level of the deceased's disability and the nature and extent of her care needs. Turning to the pleadings in this action, I note that the writ of summons was issued on 16 June 2014. The statement of claim was served on 15 October 2015 and amended on 16 May 2019 and 4 September 2020. In this most recent iteration of the plaintiff's claim, it is alleged that as a result of being shot in the thigh at close range by a high velocity bullet, the deceased was grossly physically disabled for the rest of her life. Her mobility was severely restricted and she was unable to care for herself or her children. She developed a significant depressive illness and this further compounded her functional impairment and isolation. As a result of the development of hypovolaemic shock following the shooting, the deceased required resuscitation and blood transfusion. She suffered kidney failure as a result of being transfused with incompatible blood products. Following this initial renal insult, she went on to develop chronic kidney disease. This, in turn, materially contributed to the development of treatment resistant hypertension which, in turn, contributed in a material manner to the development of cardiac disease which resulted in her death in January 1988. The plaintiff is now seeking to establish a direct link between the shooting of the deceased in January 1972 and the death of the deceased in January 1988. There is a claim for funeral expenses. There is a claim for the value of the care provided to the deceased during her life and a claim for the value of the care which others had to provide to the deceased's children, consequent upon her inability to care for her children. There is a claim for aggravated damages in respect of the shooting itself, the aftermath in 33 Chamberlain Street and for the entire period up to the death of the deceased on the basis that during that period the defendant maintained that the soldier who fired the shot that struck the deceased was firing at a petrol bomber.

[13] Borrowing from what I said in a previous judgment arising out of the events of Bloody Sunday, the deceased died long before the setting up of the Saville Inquiry or the publication of the report which completely exonerated her. She did not live to see the publication of the Saville Report. During her life, the cloud of imputed culpability would, at least to some extent, have cast an intermittent shadow over her. There is absolutely no evidence to suggest that the deceased was actively suspected by the police of being involved in any wrongdoing on the day in question. It is clear that she was a woman of good character, with no criminal convictions and no links to any political party or paramilitary organisation. It would appear that she attended the march with her daughter, only months after the death of her husband, in support of the idea that a society should be based upon fairness, justice and equality for all irrespective of background or creed and any claim that she was anything other than an innocent demonstrator was a fabrication constructed and perpetuated by the perpetrator or perpetrators of a wrong in an attempt to avoid personal or collective responsibility for that wrongdoing.

[14] Returning now to the evidence of Helen Deery, when her mother returned home after four months in hospital, her mobility was grossly restricted and she had considerable difficulty negotiating the stairs in what was to her a new house. Her bedroom was downstairs and Helen Deery slept in the same bed as her mother with the youngest child also in this room. Incidentally, when the deceased was in hospital, the baby of the family was looked after by a relative and the other 13 children looked after themselves with input from relatives. The difficulty experienced by the deceased in negotiating the stairs meant that she could not easily access the toilet which was located upstairs and as a result, her children had to bring the deceased a bucket on occasions when she was unable to make it to the toilet. Later when the family moved to 82 Creggan Heights, because all the bedrooms were upstairs and the toilet was downstairs, the deceased often slept downstairs on the sofa and her daughter Helen slept on a chair beside her.

[15] Helen Deery in her evidence recounted that prior to the events of Bloody Sunday, the deceased showed no signs of suffering from depression, even though she had recently lost her husband and was left to bring up 14 children on her own. She told the court that her father had been diagnosed as suffering from cancer for approximately five years prior to his death and for the latter part of his illness, he had been confined to bed, being cared for by the deceased. The eldest daughter of the family, Margaret, left school when she was 14 to help her mother look the other children, after her father's death. Following her husband's death, the deceased had little time to dwell on her loss as she had 14 children to look after. Apart from this, there is very little evidence about the deceased's state of psychological wellbeing in the period immediately before Bloody Sunday.

[16] Dr Sharkey, the Consultant Psychiatrist who provided a report for the court on behalf of the defendant in this case was of the opinion that it was inevitable that the deceased would have developed significant psychiatric/psychological difficulties following the death of her husband, having regard to the fact that she had to bring up 14 children on her own in conditions of marked deprivation, if not stark poverty. I can see the obvious force of this argument. However, I accept Helen Deery's evidence that following her father's death, her mother did not show signs of deep or significant depression, primarily because she just had to get on with life and look after her children. The fact that she took her daughter to the civil rights' march on Sunday 30 January 1972, only four months after the death of her husband, suggests that she was intent on not letting her recent bereavement get on top of her and she was determined to remain involved in her community, despite her loss.

[17] I also accept the evidence of Helen Deery when she recounted that the presentation of the deceased changed markedly after her return from hospital. It is clear that the deceased became significantly depressed. She was unable to look after her children or perform the heavier aspects of housework. Helen left school when she attained the age of 14 in order to help Margaret look after their mother and the

younger children. The deceased was largely confined to the house and was unable to venture out much. The older children had to do the shopping.

[18] The deceased, a relatively young woman, was left with what was, in effect, a useless left foot. She seems to have been vulnerable to the development of pressure ulceration in her left foot and ankle. These pressure sores required regular dressing and this task was performed by the older children. Her mobility was greatly impaired. Regardless of whether she used one crutch, two crutches, or a stick, the deceased was left with a powerless and largely insensate left foot and required a calliper to mobilise. Her difficulties mobilising would have been increased by reason of the presence of pressure ulceration which required prolonged dressing. It really cannot be sensibly argued that the deceased's mobility would have been anything other than greatly impaired.

[19] The deceased's housing conditions were poorly suited to her level of disability. She became socially isolated as a result of being largely confined to her home. Helen Deery remembers that her mother cried a lot and was saddened by the fact that her children had to care for her rather than her being able to care for her children. Her evidence was that prior to Bloody Sunday, her mother sang to her children and regularly told them bedtime stories. However, she could not remember this happening after her mother came back from hospital. She remembers her mother being frightened when soldiers entered the street where they were living and she also remembers her mother asking "how could people ever say that she was a petrol bomber?"

[20] One graphic example of how difficult things were in the house is how the bed linen was washed. Helen Deery gave evidence that sheets were washed in the bath and the little ones got into the bath to jump on the sheets. The sheets were then rinsed and wrung out and spread out on a fire guard in front of the fire to dry. There was no washing machine. Helen Deery remembers how difficult it was getting the children out for school in the morning. This was in an era prior to the provision of domestic care and home help by Social Services.

[21] As the children got older, some got married and moved out and the younger ones graduated to take on the role of carer for their mother and their younger siblings. Most of the children left school after the age of 14. The deceased was taken to court because the poor school attendance of her two twin daughters Bridie and May (born in December 1963). Helen Deery got married in 1979. She and her husband lived in the house for a year after her marriage. Thereafter, although she had her own accommodation, she returned every day to her mother's house to help her.

[22] Prior to her getting married in 1979, Helen Deery remembers that she usually slept with her mother. She remembers that the deceased suffered from nocturnal urinary frequency. She would have to urinate three to four times per night, using a

bucket and Helen vividly remembers that there was an awful smell which she now attributes to her mother's chronic kidney disease. Bearing in mind that this issue was not really highlighted by the family when giving histories to the care experts retained by the parties in this case, one has to be careful when assessing the weight to be attached to this evidence about urinary frequency. I also note the history recorded by Dr Fogarty when he spoke to Helen Deery on the telephone in September 2018. At that time he recorded that "She thinks that she did pass urine at night but she is not sure." Be that as it may, I am struck by the compelling evidence of an awful smell and I am satisfied that there were many occasions when Helen had to assist her mother with her toileting and that her urine was malodorous.

[23] Helen Deery was asked about her mother's smoking habit and she accepted that her mother was a heavy smoker, smoking 40 cigarettes per day. One wonders how she was able to afford this with 14 children to feed and look after but I accept that her disability, depression and isolation certainly could have contributed to the development of a heavy smoking habit. What I do not accept is Helen Deery's claim that her mother did not inhale when she smoked and only smoked in order to have something to do. The likelihood is that heavy smoking over a number of years by this relatively immobile and disabled woman took its toll on her health and materially contributed to the cardiac condition that resulted in her fatal heart attack.

[24] In the prosecution of this action, the plaintiff has obtained independent expert medical reports from a number of sources, all of whom have been compelled to provide opinions based on the contents of the limited medical notes and records that remain in existence and the recollections of the deceased's children. Reports were obtained from Mr Simpson, FRCS, and Mr McCormack, Consultant Orthopaedic Surgeons, Mr Damien Fogarty, Consultant Urologist, Dr Chenzbraun, Consultant Cardiologist, Dr Tanya Kane, Consultant Psychiatrist and Professor Fahy, Consultant Psychiatrist. The plaintiff also obtained expert reports from Mrs Theresa McCarrick, Nursing Care expert and Mrs Dearbhail Beatty, Forensic Accountant. Oral evidence was given by Professor Fahy and Mrs McCarrick. The defendant also sought input from independent medical, care and accountancy experts and reports from Mr Andrew Adair, Consultant Orthopaedic Surgeon, Dr John Sharkey, Consultant Psychiatrist, Mrs Shirley Baird, Nursing Care expert and Ms Nicola Niblock, Forensic Accountant, were produced to the Court. Dr Sharkey and Mrs Baird also give oral evidence at the hearing.

[25] Having regard to the complexity of this case and the issues raised by the evidence the court heard and received, it is important that I set out the following salient matters. Following the exchange of their medical reports, Mr McCormack and Mr Adair, discussed the case over the telephone and prepared a jointly agreed minute of their discussion. The surgeons concluded that the malunion of the femoral fracture would have given rise to progressive osteoarthritic change in the deceased's left knee joint, giving rise to increasing mobility difficulties over time. There would have been an initial improvement in the deceased's mobility in the first

two to three years following injury. This improvement would then have plateaued. Thereafter, gradual deterioration would have occurred which would have continued to progress throughout the remainder of the deceased's lifetime. Changes leading to reduced mobility would have been those secondary to arthritis, neuropathy, leg weakness, skin ulceration and the requirement for dressings. The surgeons agreed that the description of the deceased's largely bedroom based existence in her later years can best be explained by the direct physical effects of the injury combined with her general medical and psychological state of health.

[26] Professor Fahy and Dr Sharkey also discussed the case over the telephone following the exchange of their medical reports and they prepared a jointly agreed minute of their discussion. They agreed that the deceased was psychologically vulnerable prior to the shooting on account of her family and social circumstances. In the absence of injury, it is likely that the stresses of being a widowed single parent of 14 children with limited finances in troubled times would have led to periods of anxiety and low mood and that a common pattern of medical consultation in such a situation might involve attendance with a General Practitioner for occasional courses of benzodiazepines or sleeping tablets. Dr Sharkey was of the opinion that there were sufficient psychosocial risk factors in this case such that periods of moderate depression requiring antidepressant medication could have persisted until the youngest children became more independent. Professor Fahy disagreed with this pessimistic assessment. In his opinion, there is insufficient evidence to suggest that the deceased would have become clinically depressed or that low mood would have impaired her ability to function in her domestic role, impair her relationships with family or require treatment interventions for depression.

[27] Both psychiatrists agreed that the nature and severity of the injury suffered by the deceased on Bloody Sunday and her subsequent complex medical problems would have led to the development of a clinically significant psychological injury, even in a psychologically resilient person. The risk psychiatric injury in this instance was even higher in view of the deceased's pre-existing psychosocial vulnerability. There was clearly a heightened risk of her becoming overwhelmed by the combination of her pre and post-injury domestic responsibilities and her physical injuries. Crucially, both experts agree that the deceased suffered from a treatment resistant major depressive disorder in the aftermath of Bloody Sunday, which probably persisted on a fluctuating basis for the rest of her life, contributing to her high level of incapacity. The key point of disagreement between the two psychiatrists is that while Dr Sharkey is of the opinion that even without the added insult of Bloody Sunday, the deceased, due to pre-existing vulnerability and continuing domestic stresses, would probably have suffered from clinically significant anxiety and mood disturbance amounting to a moderate or moderately severe psychiatric injury, Professor Fahy does not consider it likely that the deceased would have developed a psychiatric illness leading to significant or marked functional impairment or damage to familial relationships, if she had not been caught up in the events of Bloody Sunday.

[28] Both psychiatric experts maintained these positions during examination-in-chief and cross-examination when giving oral evidence by remote means during the hearing of this action. Dr Sharkey was of the opinion that it was not possible to place reliance upon the evidence of the children of the deceased in relation to the issue of the state of mental health of the deceased in the period prior to and subsequent to Bloody Sunday. I do not accept this proposition. Naturally, care has to be taken when evaluating the evidence of Helen Deery on this issue. However, children are acutely sensitive to changes in a parent's mood and mental state. The clear evidence is that the deceased sang to the children and told them stories before Bloody Sunday but not afterwards. The clear evidence is that the deceased was frequently reduced to tears after Bloody Sunday but not before. The deceased took her daughter to the civil rights march that day. The deceased's husband had been ill for years, getting progressively worse. His death was not a shock and in a cold analysis of the burden of care faced by the deceased, before her husband's death, he would have been unable to contribute meaningfully to the care of his children due to illness and would have required significant care. As a result of his death, it can be stated that the care burden imposed upon the deceased did not increase, it would have diminished. All these factors lead me to conclude that there is no direct evidence and no compelling circumstantial evidence to support the opinion that the deceased was suffering from a significant psychiatric or psychological injury prior to Bloody Sunday. However, that is not to say that the deceased would not have developed a significant condition even in the absence of being caught up in the events of Bloody Sunday because of other adverse life events. That issue still has to be addressed.

[29] Before addressing that issue I wish to say one thing about the issues covered by the psychiatric experts in their joint minute. In paragraph 12 of the joint minute the following statement is set out: "We have considered the criteria for psychiatric damage in the "Green Book" guidelines. Here there is a slight difference between the doctors. In paragraph 13 of the joint minute there is an assertion by Dr Sharkey that it is more likely than not that the deceased "would have had symptoms of anxiety and depression equivalent to moderate-moderately severe psychiatric damage (according to the Green Book criteria)."

[30] The Green Book contains guidelines for judges and practitioners to assist them in the assessment of quantum in personal injuries cases. The goal is to ensure that where an award of damages is appropriate for personal injuries, those who are injured receive their full entitlement and those who are injured are treated consistently by differently constituted tribunals. It is inappropriate for medical experts, regardless of the nature of their expertise, to be requested to provide or to offer an opinion on which bracket or category in the Green Book a case falls into. That is not part of their legitimate role and function in giving evidence in a personal injuries case. Their legitimate role and function extends to, where possible and appropriate, the careful examination of the injured person (including the obtaining

of a comprehensive history), the consideration of all the available medical notes and records relevant to the expert's field of expertise, the consideration of collateral histories (where possible and appropriate) and thereafter, where possible, providing a clinical diagnosis, opining on issues of causation and commenting on the nature, extent, duration, significance (including functional impact), aetiology and authenticity of complaints and symptoms expressed and exhibited by or attributed to the injured party. Their legitimate role and function do not extend to the provision of an opinion on the bracket or category in the Green Book into which a case should be placed as to do so is, at least, indirectly, to provide an opinion on the level of compensation which should be awarded. To do so is to stray outside their field of expertise and to usurp the function of the tribunal charged with determining such issues. I hope I have made my view clear on this issue and for the avoidance of doubt I do not wish to see references to the Green Book in medical reports or experts' joint minutes in future.

[31] Turing then to the issue that divides the psychiatric experts in this case; I am acutely aware of the difficulties faced by the experts in this case, having regard to the absence of potentially relevant notes and records, the inability to examine or obtain a history from the injured person, the passage of time and the impact that this has on any available collateral history and, indeed, the potential that the content of any collateral history given by a family member in this case could be influenced by self-interest. The experts in this case realistically and properly admit that their opinions are somewhat speculative and in the context of "legacy" personal injuries litigation, there must come a stage when the reliance upon such speculative opinion evidence risks calling into question the integrity of the entire judicial process. The simple answer is that we do not know what the state of the deceased's mental health would have been in the absence of the events of Bloody Sunday. The knowledge I am referring to in the previous sentence is being able to state with any degree of confidence that, on the balance of probabilities (it being more likely than not), the deceased would have suffered clinically significant mental health difficulties impairing her overall functioning and diminishing her quality of life in the years after her husband died even if she had not been caught up in the events of Bloody Sunday.

[32] What the court can conclude on the basis of all the evidence available to it including the expert medical evidence is that following Bloody Sunday, as a direct result of the events of Bloody Sunday and as a consequence of the physical injuries sustained by the deceased on Bloody Sunday, it is more likely than not that the deceased suffered from a significant and disabling mental illness which persisted with fluctuating symptomology for the rest of her life and the court will, in due course, place a monetary valuation on that injury, having due regard to the guidance contained in the Green Book. The court can also conclude that the nature, severity and duration of this illness was, in all likelihood, materially influenced by the deceased's personal, familial and socio-economic circumstances but that is probably true in all such cases and the defendant must take its victim as it finds him or her.

Finally, I consider it reasonable to conclude that the death of deceased's 23 year old son Michael as the result of a violent assault in March, 1986 and the death of a second son Patrick in 1987 at the age of 31 would, inevitably have negatively impacted upon the fragile mental health of the deceased.

[33] The next discreet medical issue which the court has to adjudicate upon is whether, as is asserted by Dr Fogarty, FRCP, the acute kidney problems experienced by the deceased following the transfusion of incompatible blood products, gave rise to the development over time of chronic renal impairment which, in turn, contributed to the development of treatment resistant hypertension which, in turn, contributed the development of cardiac disease and the occurrence of the heart attack which caused the death of the deceased in January 1988. Before discussing this issue in detail, four preliminary matters should be addressed.

[34] Firstly, the assertion made by Dr Fogarty, FRCP, clearly involves a degree of speculation on his part. There is no record of a diagnosis of chronic kidney disease nor is there any record of a diagnosis of hypertension. The history provided by family members to the plaintiff's care expert does not contain any account which would support a diagnosis of either condition. The history given by the family to the defendant's care expert does refer to a diagnosis of hypertension. The reports prepared by Dr Panesar, FRCS, and Dr Anne Doherty do not give any support to the diagnosis of either condition. These reports are by clinicians who actually assessed the deceased in her own home in the late 1980s. Dr Doherty specifically states that she has no recollection of the deceased having any renal problems and cannot be specific about what medication the deceased was prescribed although she feels that it "would have been likely that she was on medication for her mood." Dr Fogarty did not have an opportunity to examine the deceased and he did not have the opportunity to consider her General Practitioner's notes and records. I repeat what I said above about reliance upon such speculative opinion evidence in "legacy" type cases.

[35] Secondly, it appears to be asserted on behalf of the plaintiff that because Dr Fogarty's opinion is not countered by the opinion of an appropriately qualified expert in the relevant field of medical expertise, the court has, in effect, no choice but to accept Dr Fogarty's opinion. I cannot accept such a proposition. Even in the absence of a contrary or countervailing opinion, the court's duty is to carefully examine and test the opinion of any medical expert in order to ascertain whether that opinion should form the basis of a finding by the court. Naturally, the absence of a contrary or countervailing opinion is a relevant consideration. The fact that the defendant has chosen to allow the report containing that opinion to be adduced in evidence without the need of formal proof and does not require the author of the report to give oral testimony and be subject to cross-examination is also a relevant consideration. I must stress, however, that these considerations are not and should not be determinative of the issue to be decided by the court.

[36] Thirdly, in relation to the issue of what caused the deceased's heart attack, one cannot ignore the elephant in the room. The deceased, on the plaintiff's case, had significant problems with mobility and was in later years largely confined to her bedroom. She smoked 40 cigarettes per day. She was significantly depressed. As is recognised by Dr Chenzbraun, FRCP, the plaintiff's cardiology expert, such a heavy smoking habit, by itself, is a significant risk factor for heart disease. Helen Deery's evidence about her mother not inhaling the smoke from the cigarettes that she smoked does not withstand scrutiny. The deceased was largely immobile in a small room going through 40 cigarettes per day. What air was she breathing in? What was in that air? We are told of the dangers of passive smoking. Smoking bans in workplaces and other public places are based on the risks to health of passive smoking. It is undoubtedly the case that the deceased inhaled harmful cigarette smoke over a long number of years and the cumulative impact of this is clearly set out in Dr Chenzbraun's report.

[37] Fourthly, the plaintiff in her amended pleadings has not made out the case that the heart disease which resulted in the death of the deceased was caused or materially contributed to by reason of the deceased's immobility, her depression and her smoking habit, these three factors having their origins in the events of Bloody Sunday. In fact, the deceased's smoking habit is not mentioned in the pleadings at all. As stated above, the plaintiff's case is that the deceased suffered an acute kidney injury that resulted in the development of chronic kidney disease that resulted in the development of severe hypertension that caused or contributed to the heart attack that resulted in the death of the deceased. In an adversarial process, governed by formal pleadings, it is not open to the court, of its own motion, to examine and adjudicate upon the merits of a particular case, in the absence of such a case being alleged and pleaded. The duty of the court is to examine and adjudicate upon the merits of the case that is being alleged and pleaded by the plaintiff but in doing so the court cannot and should not ignore direct and/or circumstantial evidence which may point to alternative chains of causation or different aetiological pathways. However, in the context of adversarial proceedings, governed by a system of formal pleadings, the examination of such alternative chains of causation or different aetiological pathways is limited to testing the strength of the case made out by plaintiff and, in the absence of the plaintiff applying for leave to adopt and rely upon an alternative case, it would be inappropriate for the court, of its own motion, to make a finding against a defendant, if an alternative chain of causation or different aetiological pathway which had its origins in the defendant's wrongdoing was made out.

[38] Turning now to Dr Fogarty's report dated 11th September, 2018, he is of the opinion that the deceased developed a severe acute kidney injury as a result of being transfused with mismatched blood. He states that the deceased required dialysis for "~3 weeks." This is not supported by the available documentation. The letter written by Dr McGeown, Consultant Nephrologist, dated 21 February 1972 states that "peritoneal dialysis was commenced on the 5 February (a form of artificial

kidney treatment), and this was continued until the 12 February"; a period of one week. Therefore, Dr Fogarty's comment that the "loss of renal function for almost a month is notable" does not appear to be supported by the available records. Dr Fogarty states that the deceased, after her return home from hospital "was largely housebound and in later years bed bound. She had difficult to control high blood pressure what we now call resistant hypertension." The evidence for this comes from Dr Fogarty's telephone conversation with Helen Deery on 13 September 2018 during which Dr Fogarty was informed that the deceased was greatly troubled by headaches. She also informed Dr Fogarty that the deceased's General Practitioner Dr Donal McDermott had carried out frequent home visits and had noted that the deceased's blood pressure was elevated. Mrs Deery stated that she remembered her mother being on "perhaps 3 blood pressure tablets (unsure if up to 3 times a day or 3 separate tablets)."

[39] The only other expert to specifically address the issue of hypertension is the Plaintiff's cardiology expert, Dr Chenzbraun, FRCP. His report is dated 2 December 2018. He makes the following points. In relation to the deceased's alleged hypertension, there is no available data on the severity of arterial hypertension or whether it was properly controlled by medication. The family reports high blood pressure values and frequent severe headaches and Dr Fogarty presents this information as supporting a diagnosis of poorly controlled severe arterial hypertension. Dr Chenzbraun states that "this is a possible assumption but I could not find any data (GP notes, actually measuring BP values) to support this scenario." He then goes on to state in a subsequent passage of his report: "The presence of severe renal failure and related poorly controlled hypertension would be additional life shortening factors" (in addition to reduced mobility and smoking) "but their presence is inferred not proved – this is the case especially for the diagnosis of uncontrolled hypertension that is advanced by Dr Fogarty in view of the family witness statements relating to severe episodes of headache and the likelihood of severe hypertension in the presence of advanced renal failure." He then concludes his report by stating that:

> "If the deceased had indeed developed advanced kidney disease and severe, poorly treated hypertension as reasonably advanced by Dr Fogarty, then these conditions should be seen as contributing to her premature death. However, both these conditions are assumed, not proven, and this is, in my opinion, true especially of the diagnosis of severe hypertension. The only actually documented risk factor for the deceased's premature death remains her heavy smoking that in itself would have led to a significant loss of life expectancy….The additional contribution of the postulated renal failure and hypertension would be difficult to quantify."

[40] According to Dr Chenzbraun, FRCP, the relevant ONS data would indicate that the life expectancy of a woman born in 1933 in the UK was 63 years without adjustments for socio-economic or family status. Accordingly, the deceased's death would qualify as a premature death and the assumed mechanism at the time was acute myocardial infarction. The shortening of the deceased's life expectancy was "most likely multifactorial if one takes into account her heavy smoking, reduced mobility and her assumed advanced renal failure and severe hypertension." Dr Chenzbraun, FRCP, notes that a history of smoking has by itself been credited "with a loss of 10 years of life expectancy." In essence, Dr Chenzbraun, FRCP, is stating that the history of smoking could by itself account for the premature death of the deceased.

[41] Returning to Dr Fogarty's report, he largely agrees with Dr Chenzbraun's estimate of unimpaired life expectancy. He quotes a figure of 62 years. He states that "there is a distinct possibility that her premature death, deemed a heart attack, was significantly contributed to by the residual effects of the AKI" (acute kidney injury) "with hypertension and Chronic Kidney Disease driving things." The use of the phrase "distinct possibility" is important and it does not in my view equate to a causal link being established on the balance of probabilities in the sense of being "more likely than not." This is particularly so when, in the previous sentence, Dr Fogarty expresses his opinion using the following language. "Given the blood pressure drugs and targets used in the 70s and 80s it is my guess that when she died she had much more advanced renal failure than anyone knew or considered with a GFR" (glomerular filtration rate) "of <30% and perhaps as low as 10-15% or worse." The use of the phrase "it is my guess", strengthens my view that the use of the phrase "there is a distinct possibility" does not equate to "it is more likely than not."

[42] Examining each part of Dr Fogarty's hypothesis in turn, it is undoubtedly the case that the deceased suffered an acute kidney injury (acute tubular necrosis) as a result a mismatched blood transfusion. Dr Fogarty also raises the possibility that the treatment of the deceased's wound infection with the antibiotic gentamycin may have contributed to acute tubular necrosis. However, there is no clear evidence in the available notes and records of a deterioration in kidney function after the administration of gentamycin which would allow the court to conclude that the administration of gentymycin contributed to the acute kidney injury in this case.

[43] Turing to the hospital admission in February, 1973, Dr Fogarty, FRCP, queries whether this was a sign of chronic kidney damage. The deceased's admission can readily be explained by the presence of a small kidney stone which temporarily blocked the left ureter. If the production of this stone had somehow been related to the ongoing development of chronic kidney disease, would one not have expected to have seen other subsequent admissions with similar complaints and findings? Clearly, there aren't any. Further there is a blood pressure reading during this admission of 160/100. This is clearly elevated; but that could be linked to the stress of the admission to hospital with severe pain. Doctor Fogarty, FRCP, does not

comment on this blood pressure reading or whether any significance can be attached to it. There is a further more normal blood pressure reading recorded on 10 February 1973 of 130/80 which again is not commented upon.

[44] Further, Dr Fogarty does not comment on a blood pressure reading of 140/80 which is recorded in a pre-operative anaesthetic assessment carried out before the examination under anaesthetic at Altnagelvin Hospital on 7 March 1972 or the blood pressure reading of 140/90 which is recorded in a pre-operative anaesthetic assessment carried out before the skin grafting operation at Altnagelvin on 18 April 1972. He does, however, comment on the series of blood pressure readings which are recorded prior to and during her operation on 13 June 1976. The record of the pre-anaesthetic assessment indicates that the chest was clear. In relation to her cardio-vascular status, the note reads: "NAD" i.e. "no abnormality diagnosed." Her blood pressure on that occasion was 130/80 which certainly does not indicate severe hypertension. She is described as obese. She is noted to have dentures. (There is a note of a dental clearance on 12 April 1972, during her previous lengthy admission to Altnagelvin). Her emotional state is described as stable. During the operation, systolic blood pressure readings commence at 130, drop to 120, return to 130 and then climb to 140. There is nothing to indicate severe hypertension and there is nothing to indicate that the anaesthetist considered that there were any significant co-morbidities which gave rise to an increased anaesthetic risk. Does this tie in with the development of chronic kidney disease and severe treatment resistant hypertension? At page nine of his report, I believe that Dr Fogarty, FRCP, implicitly accepts that it does not. His argument that the intraoperative blood pressure readings are lowered by the general anaesthetic does not appear very attractive when one notes that the pre-operative systolic blood pressure was 130. Further, he appears to attempt to minimise the significance of these blood pressure readings by repeating the history given by Helen Deery.

[45] In relation to the radiological abnormality in the left kidney noted during the admission in February 1973, Dr Fogarty, FRCP, comments that the "structural abnormality has most likely developed associated with the AKI and certainly added to her risk of longer-term severe hypertension and CKD." However, if one reads the discharge letter dated 2 March 1973, the formal IVP report is quoted and this report states:

> "A delayed film taken in 2 hours showed clubbing of the lower pole calyces on the left. The changes are due to obstruction in the ureter draining the lower pole moiety of the left kidney. A tiny opacity in the left side of the pelvis could well be a ureteric calculus."

I am not sure how this enables Dr Fogarty, FRCP, to conclude with any degree of confidence that the "structural abnormality has most likely developed associated

with the AKI" when the Consultant interpreting the IVP concluded that the changes were due to obstruction of the ureter.

[46] Dr Fogarty, FRCP, draws on a number of studies which he states supports his conclusion that patients who suffer acute kidney injury that required dialysis have a high risk of going on to develop chronic kidney disease. He states that acute kidney injury appears to be associated with a higher risk of chronic kidney disease even among relatively low risk patients such as the deceased. He states that the research indicates that the increased risk of chronic kidney disease sets in at a relatively early stage after the acute kidney injury (an almost two fold risk after 3.3 years) and that the risk increases in a linear fashion thereafter so that there would be an almost four fold risk of chronic kidney disease after 6.6 years. Be that as it may, having regard to the available records relating to the Achilles tendon operation in June 1976, including the pre-operative anaesthetic assessment record, to which Dr Fogarty had access, it does not appear to be the case that over four years after the acute injury, there were any signs of acute kidney failure. Certainly Dr Fogarty, FRCP, has not been able to point to any such evidence.

[47] Relying on the research studies that he has referred to in his report, Dr Fogarty concludes that at a point in time 16 years after her acute kidney injury there was an 80% to 90% chance that the deceased had moderate to significant chronic kidney disease. In his opinion, the deceased's treatment resistant hypertension (assumed to be present on the basis of the collateral history given by Helen Deery) "would have been created or at least made worse by the previous severe AKI and residual CKD." In the concluding paragraphs of his report, Dr Fogarty, FRCP, states that there is a strong chance (80% to 90%) that the deceased would have had "residual chronic kidney disease/damage." He states that the risks of hypertension and proteinuria are elevated in such patients and rise over time. He concludes that "proteinuria and hypertension are both independent risk factors for accelerated cardiovascular disease and could have been relevant in her subsequent death from a heart attack in her mid-50s." The use of the phrase "could have been relevant" does not in my opinion equate to an expression of an opinion that relevance was established on the balance of probabilities. In relation to the issue of smoking, the only reference to this glaringly obvious risk factor for heart disease in Dr Fogarty's report is contained in page 3 where he records that Helen Deery gave a collateral history of her mother's smoking habit in the following terms: "She did smoke a few cigarettes but did not inhale."

[48] I repeat what I stated at paragraphs [31] and [34] above that in the context of "legacy" personal injuries litigation, there must come a stage when the reliance upon speculative opinion evidence risks calling into question the integrity of the entire judicial process. There was no diagnosis of chronic kidney disease during the lifetime of the deceased. There is no extant documentation supporting a diagnosis of severe treatment resistant hypertension. The pre-operative anaesthetic assessment carried out in June 1976 does not support a diagnosis of either condition at that time.

The General Practitioner who regularly attended the deceased between 1984 and 1988 makes no mention of any diagnosis or treatment for hypertension and specifically does not recall the deceased having any renal problems. Assuming for one moment that Dr Fogarty, FRCP, is right about the dramatically increased risk of chronic kidney disease following on from a single episode of acute kidney injury which it would appear necessitated dialysis for one week, not three, there is no strong evidence to establish a link between chronic kidney disease and any of its potential complications and the death of the deceased. In summary Dr Fogarty's evidence is that there is a "distinct possibility" that the deceased's premature death was significantly contributed to by the residual effects of the AKI with hypertension and chronic kidney disease driving things. Further, proteinuria and hypertension are independent risk factors for accelerated cardiovascular disease and "could have been relevant" in her subsequent death from a heart attack in her mid-50s. These conclusions fall well short of persuading me that on the balance of probabilities, the deceased's acute kidney injury or any complications flowing therefrom either caused or contributed to her death 16 years later. The report prepared by Dr Chenzbraun, FRCP, provides a more compelling explanation for the deceased's premature death in January 1988, namely a prolonged history of heavy cigarette smoking and a prolonged history of reduced mobility.

[49] When it comes to placing a value on the injuries suffered by the deceased, it is important to remember that there is a complex relationship between physical and psychological injuries. Significant physical injuries can give rise to the development of significant psychological injuries which in turn can result in the victim experiencing more severe symptomology and a greater level of disability associated with the physical injury. It is important to adopt a holistic approach when attempting to provide fair and proper compensation in a case involving complex injuries with inter-related physical and psychological components. In a case involving multiple serious injuries it is seldom appropriate to place a value on each individual injury separately and then combine these individual values to achieve a total award. The Green Book is useful in that it gives guidance in respect of the range of values deemed appropriate for an injury of the type being considered but combinations of injuries are not addressed in the guidance and for good reason as the number and variety of potential combinations would make it impracticable to do so. This means that care has to be taken when considering combinations of injuries to ensure that, by the adoption of a holistic approach, an appropriate global amount of compensation is arrived at and the claimant is neither over-compensated nor under-compensated for the injuries sustained, having regard to the short, medium and long-term consequences of those injuries.

[50] It is often argued that the figures at the top ends of various ranges or categories in the Green Book are intended to apply to injuries of that general description which give rise to the most significant symptomology and functional loss or impairment and which are likely to persist for the longest period of time. Such a broad-brush approach may in some cases result in important individual

considerations being overlooked. As an example, one can consider the approach to be adopted to the valuation of an injury which is said to be a lifetime injury. Should all lifetime injuries attract awards at the top of the relevant range or category? A lifetime may be 60 or 70 years or in the deceased's case a lifetime can be 16 years. Is an injury to be valued at the top of a range or category because every remaining minute of the injured party's life is a minute spent coping with the effects of that injury or does the word "lifetime" in this context mean a significantly prolonged duration equating to an unimpaired life expectancy? Logically, the former approach cannot be correct in that it would mean that the death of the victim a relatively short time after the occurrence of the injury would not reduce the compensation payable.

[51] However, that doesn't mean that the latter approach is universally appropriate. Common humanity dictates that some significant regard must be had to the fact that a victim had to or will have to endure the effects and consequences of his or her injury for whatever time remained or remains to them in this life, even though that time may have been or may be considerably less than an unrestricted lifetime. To know and experience no existence other than an injured one for the remainder of one's life, especially when one is aware of and completely or largely appreciates the differences to the quality of life that the injury has brought about is something worthy of recognition, even though the period concerned was or is likely to be much less than a normal lifespan.

[52] Having raised the issue of awareness, it is important to appreciate the interplay between the severity of the injury and the ability to perceive the severity of the injury. This interplay is most clearly seen in the context of a severely brain injured victim. In some types of brain injury, the more severe the injury, the less awareness or appreciation of his or her plight the victim has. Is it fair or just for a more severely injured victim of a brain injury to receive less compensation than a victim of a less severe injury with greater awareness simply because the injury has robbed the more seriously injured victim of the ability to appreciate the catastrophic nature and extent of his/her injuries? Surely, in cases of impaired awareness, the justice of the situation requires the amount of compensation to properly and fully reflect the catastrophic nature of the injury suffered? And yet, awareness and appreciation are very important when it comes to assessing the loss suffered by that injured individual? A holistic approach is vital. Returning to the circumstances of the present case, where significant physical injury precipitates the development of a significant psychiatric injury which in turn exacerbates and heightens the awareness of symptomology and level of debility resulting from the physical injury, to which aspect of the victim's injury does one attribute the increase in symptomology and debility; the physical or the psychological? That difficult issue can be sidestepped and justice can still be done by adopting a holistic approach. Indeed, there is much less likelihood of justice not being done in the sense of too little or too great an award of compensation being made, if such a holistic approach is adopted.

[53] The last issue of general application that I wish to raise is the approach to be adopted to compensating a victim for prolonged hospital stays, repeat procedures, especially procedures or operations under general anaesthetic, protracted courses of medical or therapeutic intervention and prolonged and debilitating infections. The Green Book guidance for specific types of injury is sufficiently flexible to provide adequate compensation for injuries of that type that are complicated by one or more of the complicating factors referred to above. Such factors would clearly place a particular injury closer to the top of the range than might otherwise be the case when just looking at the injury in isolation. However, there will, inevitably, be cases when the complicating factors are so severe or significant or protracted that separate and discreet consideration should be afforded to them. This is one such case. The prolonged hospital stay, the wound infection, the sinus formation, the need for prolonged dressings, the traction nails inserted in the tibia and os calcis, the Thomas splint, the numerous examinations under general anaesthetic, the pressure sores, the skin grafting, the Achilles tendon operation are all compensatable consequences of the orthopaedic injury. In addition to these matters, one must discreetly consider the transfusion related kidney failure, the transfer to a hospital remote from her children for a prolonged period, and the need for dialysis during the period of acute kidney failure. But having evaluated the significance of each of these discrete matters, the court must adopt a holistic approach in an effort to award full, fair and proper compensation.

[54] Before I commence this task, I must specifically record that Mr Ringland QC, when an enquiry was made about the issue of causation at the commencement of the hearing, specifically stated that the defendant was not making the case that the administration of unmatched blood products constituted a *novus actus interveniens*. This means that the estate of the deceased is entitled to compensation for the full consequences of the transfusion injury.

[55] Finally, before turning to the assessment of general damages in this case, I must deal with the issue of aggravated damages. In my earlier judgments arising out of the events of Bloody Sunday I have provided clear and comprehensive guidance on the principles applicable to the awarding of aggravated and exemplary damages. I do not propose to further lengthen this judgment by repeating what I said in those judgments. The two basic preconditions for an award of aggravated damages are:

(1) exceptional or contumelious conduct or motive on the part of a defendant in committing the wrong, or, in certain circumstances, subsequent to the wrong; and

(2) mental distress sustained by the plaintiff as a result.

[56] In examining the events of the day in question the court has no hesitation in finding that the wrongful actions of the servants or agents of the defendant on the day in question gave rise to emotions of extreme fear if not terror in the mind of the

deceased. The court has no hesitation in finding as a fact that the behaviour of the soldier who shot the deceased and the behaviour of the soldier who entered 33 Chamberlain Street and uttered words that I will not repeat in each instance was exceptional and contumelious and in each instance was imbued with a degree of malevolence and flagrancy which was truly exceptional. In the circumstances, the court determines that the claim for injury to feelings for the events of the day in question and the immediate aftermath including the incident in 33 Chamberlain Street is clearly established in law and that the compensation to which the estate of the deceased is entitled should include aggravated damages and the appropriate level of award is the sum of £25,000.

[57] An award of aggravated damages is designed to provide compensation for mental distress actually suffered by the deceased which would otherwise not be the subject of an award of compensation. In this instance, as I am determined to award the estate of the deceased full and fair compensation for the psychological injury suffered by the deceased after Bloody Sunday, this will take into account the mental distress which she undoubtedly suffered by reason of the approach adopted by the defendant to those killed and injured during Bloody Sunday in the period between the end of January, 1972 and the date of the deceased's death on January, 1988.

[58] Bearing in mind what I have set out above, I am not satisfied that it would be appropriate to make any further award for aggravated damages in this case. In assessing the level of compensation to which the estate of the deceased is entitled for the psychological injury suffered by the deceased, I am satisfied that the deceased did suffer injury to her feelings in the period between 1972 and her death in 1988 as a result of the approach adopted by the defendant and its servants to those shot during Bloody Sunday and this should be appropriately reflected in the award of damages made in relation to her psychological injury.

[59] Having considered the guidance afforded by the Green Book and the written submissions of counsel for the plaintiff and the defendant, I conclude that the appropriate category is category K. (e)(iv) at page 38 of the latest edition but as stated above at paragraph [53], the prolonged course of the deceased's inpatient and out-patient management for her leg injury means that discreet consideration must be afforded to these complications and, therefore, I consider that the sum of £130,000 would appropriate for leg injury sustained in this case.

[60] In relation to the psychiatric/psychological injury suffered by the deceased; this is described as a treatment resistant major depressive disorder which manifested itself in fluctuating symptomology for the rest of the deceased's life. Having regard to the guidance contained in pages 12 and 13 of the Green Book, the appropriate category is A. (a) severe psychiatric damage but because of the overlap between the functional impairment associated with the physical injuries and psychological injuries, one has to be careful to avoid double compensation. An award of £85,000 is appropriate for the psychological injury suffered in this case, including

compensation for injury to her feelings. In setting the award at this level, I take into account the duration of the deceased's psychological injury and the inevitable impact which the entirely unrelated deaths of two of her sons would have had towards the end of her own life.

[61] In relation to the kidney injury, the Green Book affords limited guidance when dealing with the deceased's injury. She suffered an acute kidney injury which certainly predisposed her to the development of chronic kidney disease. The evidence of the actual development of chronic kidney disease is somewhat speculative. The acute kidney injury required the transfer of the deceased to a hospital remote from her family. However, it is clear that she would have been in hospital in any event in respect of her leg injury which was complicated by an injection. She required peritoneal dialysis for a week. Taking all relevant considerations into account, the appropriate award for this primarily acute kidney injury would be £25,000.

[62] Combining the four amounts set out in paragraphs [56], [59], [60] and [61] gives a total potential award of damages for non-pecuniary loss of £265,000. Taking a holistic overview of the entire case and paying full regard to the nature, extent and duration of the injuries suffered by the deceased including injury to her feelings, and bearing in mind that I have, as best as I can, tailored the individual awards to take account of any overlap in treatment, symptomology and functional impairment, I am compelled to conclude that this sum would represent slightly more that 100% compensation and that the appropriate global figure in this case is £250,000 for general damages.

[63] The next issues that I have to consider are the claims for the cost of care and the loss of caregiver contribution. Initially, there were a number of areas of dispute between the two care experts who gave evidence in this case. However, in respect of the care required by the deceased, an element of consensus emerged with the hours and rates of care being agreed with appropriate account being taken of the fact those providing the care were family members as opposed to professional carers. The agreed figure is, I understand, £17,028. The one area of dispute remaining between the care experts in respect of the issue of the care required by the deceased is whether an additional discount should be factored into the award based solely on the fact that the caregivers were children under the age of 18.

[64] The proposition that the hourly rates payable for care which is deemed to be necessary in any particular case should, in addition to the 25% discount for non-commercial care, be subject to a further 25% discount because the person or persons providing the care on a non-commercial basis is under the age of 18, does not seem at all attractive to the court. No authority from the relevant case law was put forward in support of this proposition. Mrs Baird, when giving her evidence, stated that the additional reduction was justified because the juvenile caregiver's knowledge, skills, maturity and insight are less than those of an adult family

member providing care or a professional carer. The deduction, in her opinion, was justified because of the inability of the juvenile carer to provide the same quality of care as an adult carer or a professional carer. However, Mrs Baird specifically conceded that if a deduction was dependent on the quality of care given by the care giver, this would be a departure from the usual approach to the costing of care in such cases which involves assessing the nature and extent of the care needed and then costing that care using commercial care rates, with a deduction (usually of 25%) being applied if the care was or will be provided by family members, on the basis that family carers do not have to account for income tax or national insurance. The quality of care provided by family members is not normally taken into account when assessing the appropriate rate of payment. Mrs Baird accepted that if it was appropriate to take into account the quality of care provided in this case when assessing the value of that care then it would be appropriate to carry out such an assessment in every case in which family members were carrying out caring tasks and duties and such an approach would constitute a novel departure in terms of the method usually adopted for assessing the cost of care. In the circumstances of this case, I do not consider it appropriate to factor in an additional discount because the agreed necessary care was provided by family members under the age of 18.

[65] The final issues I have to determine are whether, in the context of a claim brought on behalf of the estate of a deceased victim, it is possible for the plaintiff on behalf of the estate to claim the cost of care which the deceased would have provided to others but was unable to do so by reason of injury, where the evidence is that such care as would have been provided by the deceased was voluntarily and gratuitously provided by others. If such a claim can be brought, should such a claim succeed in this case and, if so, to what extent?

[66] If the deceased had, at her own expense, engaged the services of a home help to perform the child care tasks that she was unable to perform because of her injuries then it is clear that the deceased during her lifetime could have sought to recover those costs and the plaintiff, on behalf of the estate of deceased, would be entitled to seek to recover such costs actually incurred by the deceased during her lifetime. In *Daly v General Steam Navigation Company* [1981] 1WLR 120 CA, the Court of Appeal of England and Wales extended the ambit of this principle to include the situation where a wife was, as a result of injuries, rendered partially incapable of undertaking housekeeping duties and required assistance from her husband. The couple did not engage paid help but the Court of Appeal held she was entitled to claim for the cost of such help from the date of trial onwards, even thought there was nothing to indicate that the plaintiff would actually engage such paid help going forward.

[67] However, the Court of Appeal went on to hold that the plaintiff in that case was not entitled to claim the cost of labour, which was no doubt needed, but was not engaged, between the time of the accident and the date of trial. The court held that this was an expense which was actually known not to have been incurred. Instead, an additional amount was paid by way of general damages for loss of amenity

during this period. Applying the *Daly* decision with its full rigor would mean that the estate could not claim for a loss which was actually known not to have been incurred.

[68] The plaintiff seeks to rely on the authority of *Regan v Williamson* [1976] 1 WLR 305 but it must be remembered that this case was a first instance decision predating the *Daly* decision which in any event dealt with the situation where the acts or omissions of the defendant actually caused the death of the deceased. This, as I have found, is not the situation here. The ratio of the *Regan* case which has no bearing on the present case is that in determining the pecuniary value to be put on the services of a deceased mother, acknowledgement should be given to the constant attendance of a mother on her children, and, accordingly, the value placed upon such services should not be limited to the mere computation of the costs of a housekeeper less the cost of the deceased wife's maintenance.

[69] The Court of Appeal in England and Wales revisited the area of law presently under discussion in the case of *Lowe v Guise* [2002] EWCA Civ 197. That case involved the determination of a preliminary issue about whether the injured plaintiff who had previously provided care for his disabled brother and who was, as a result of his injuries, restricted in his ability to provide such care, was entitled to claim for the value of the care which he was not then able to provide to his disabled brother, but which was provided on a gratuitous basis by another member of the family, namely, his mother. Rix LJ carried out a careful exposition of the relevant principles and came to the conclusion that the plaintiff could in principle mount such a claim and that there should be no difference in approach between the assessment of the value of the claim for the period between accident and trial and the period following the trial. Morland J agreed.

[70] Potter LJ agreed that, in principle, in respect of the ability to make such a claim but he felt bound by the authority of *Daly* to conclude that a different approach would have to be adopted to the assessment of future loss and past actual loss on the one hand and to past notional loss on the other. In the concluding section of his judgment, he made the following observations.

> "[52] The decision in *Daly* duly established that in an appropriate case loss of the claimant's ability to do unpaid work in the home for the benefit of the family is a recoverable head of damage. It seems to me that the principle recognised is applicable to cover the position not only of a spouse, but also of a member of the family, such as the claimant in this case, who acknowledges and undertakes the obligation to carry out household and other tasks for the general benefit of the family of which he or she is a member and without which, following his or her disablement, it is necessary to obtain a substitute,

whether that substitute is someone who is remunerated for such services or is another member of the family who has not previously performed the relevant tasks but gratuitously agrees to take them on, over and above the previous arrangements reasonably adopted by the family. If the task in question is the care of a disabled member of the family rather than some more humdrum family activity, it is not thereby removed from the category of recoverability on the grounds (as the judge put it) that the gratuitous services were for the benefit of the brother alone; nor is there any reason in logic or humanity why that should be so.

[53] Within that head of damage, where the services have been supplied gratuitously and are thereafter performed by another, also gratuitously, a subsidiary problem arises as to the basis upon which the loss or value of the services is to be assessed. In particular, if the court adopts the yardstick of a reasonable rate of remuneration for the hours worked, does such yardstick fall to be applied both to special damage (i.e. pre-trial loss) and future loss? In *Daly* at first instance, Brandon J adopted a consistent approach as between the two, treating the award of special damages as a simple matter of calculation based on the appropriate notional cost of supplying the services and, similarly in respect of future loss, by use of an appropriate multiplier applied to a multiplicand based on the cost of providing the housekeeping services which the claimant would in future be unable to perform, regardless of whether an outsider would in fact have been employed to provide those services. Brandon J's method in respect of future costs was approved by the Court of Appeal. The court (while acknowledging the lack of logic involved) took the view that the figure for special (i.e. pre-trial) damages had to be assessed on the basis of actual rather than notional loss, being limited to the amount actually expended on substitute services, any part-time earnings lost by the claimant's husband in looking after her, and an augmented sum by way of general damages for pain, suffering and loss of amenity up to trial.

[54] In its 1999 report 'Damages for Personal Injury; Medical Nursing and Other Expenses; Collateral Benefits' (Law Com No 262), already quoted by Rix LJ, the Law

Commission recommended (inter alia) that where a claimant has suffered loss of, or reduction in, his or her ability to do work in the home:

(1) This should be compensated as past pecuniary loss where the claimant has reasonably paid someone to do the work, and as a future pecuniary loss where the claimant establishes that he or she will reasonably pay somebody to do it.

(2) ... the claimant should also be able to recover damages for the cost of the work where the work has been or will reasonably be done gratuitously by a relative or friend ... and should be under the personal liability to account for the damages awarded in respect of *past* work, to the person .. who performed the work; but no legal obligation should be imposed in respect of damages awarded for work to be done in the *future*.

[55] The Law Commission considered that legislation would be necessary to reverse *Hunt –v- Severs* insofar as it held that no damages can be recovered where the person who has gratuitously carried out domestic work is the active tortfeasor; also to modify the trust concept endorsed in *Hunt –v- Severs.* However, the Commission expressed the view that the common law could otherwise be expected to develop so as to reach the position recommended by the Law Commission. I agree that it should so develop and that this case represents a welcome opportunity to push it in that direction.

[56] In *Swain*, I expressed the view that it was inexplicable that parliament had 'refused' to import into English law the recommendations of the Pearson Commission. As suggested by Rix LJ, it seems to me that I put the matter too strongly and that the failure of parliament in that respect does not constitute a barrier to a decision of the court in this case by way of expansion of the decision in *Daly.* I agree with Rix LJ that *Daly,* having been decided a year before the 1982 Act was passed, may well have been regarded by parliament as marking a development which rendered less pressing the need for any specific provision in English law along the lines provided by s.9 of the 1982 Act in respect of Scottish law.

> [57] Thus, I would give an affirmative answer to the first of the issues before the judge. At the same time, because this court is bound by its previous decision in *Daly,* I feel unable to follow so far as I would like in the direction in which logic and my own inclination would otherwise lead. It is therefore my reluctant conclusion that the judge who eventually has the task of assessing the claimant's damage in respect of any impaired ability to perform carer services for his brother will be obliged to assess the special damages and the future loss on the differing bases prescribed in respect of each by the Court of Appeal in that case."

[71] The Court of Appeal in England and Wales in *Lowe v Guise* was tasked with deciding a preliminary issue "of whether the claimant is entitled to recover damages [from] the defendant for carer services as pleaded." The court unanimously agreed that such a claim was a legitimate claim but disagreed in relation to how damages should be assessed. Rix LJ and Morland J, departing from *Daly*, considered that future loss, past actual loss and past notional loss should all be assessed and measured in money's worth. Potter LJ, on the other hand, felt bound by *Daly* and considered that future loss and past actual loss should be assessed and measured in money terms but that past notional loss should be assessed in terms of loss of amenity as in *Daly*. It should be noted that the ability to mount such a claim in Scotland is governed by statute. Under section 9 of the Administration of Justice Act 1982, such a claim can be made and no distinction is made between future loss, past actual loss or past notional loss. The view taken in *Lowe* was that such a provision was necessary to effect a change in the law in Scotland whereas no such change was needed in England and Wales as the common law adequately dealt with this issue.

[72] Decisions of the Court of Appeal of England and Wales are not strictly binding on this court although they should be regarded as highly persuasive authorities. I have not been able to find nor have I been referred to any authority in this jurisdiction where the issues addressed in *Daly* and *Lowe* have been discussed or adjudicated upon. In this jurisdiction, as in England and Wales, there is no statutory equivalent to section 9 of the Administration of Justice Act 1982. Bearing in mind the persuasive authority of the both *Daly* and *Lowe* and the existence of a specific statutory provision in Scotland, I am of the view that the plaintiff on behalf of the estate of the deceased in this case can mount a claim in respect of the care which the deceased was unable to provide to her children but which was provided gratuitously by others. As to how such a claim is assessed, the decisions of *Daly* and *Lowe* point in different directions and, therefore, this court must choose which if either path to follow. I hold the opinion that the common law should, where possible, develop incrementally, along logically consistent lines. It appears to me to be utterly inconsistent to allow the claim for the care provided gratuitously to the

deceased during her lifetime (an entirely nominal loss suffered by the deceased and, in turn, by her estate) to be assessed in money's worth and at the same time to hold that the nominal cost or value of the care provided by others on behalf of the deceased to the children of the deceased cannot be assessed in money's worth and such a loss can only be reflected in general damages for loss of amenity.

[73] In order to avoid such inconsistency, I hold that, where possible, such a nominal loss should be assessed in money's worth, rather than being considered as some form of non-pecuniary loss. The recent case of *Welsh v Walsall Healthcare NHS Trust* [2018] EWHC 1917 (QB), does not cause me to adopt a different approach. In that case, Yip J chose not to award damages under the principle in *Lowe v Guise* because the nature of the help provided out of normal family ties and affection by the claimant in *Welsh* was qualitatively much different than the care provided by Mr Lowe to his brother. Yip J at paragraph [118] of her judgment stated:

> "I take into account that she enjoyed doing things with and for her niece and helping her parents. Her inability to do those things after her surgery represents a real loss of amenity for her, which I have taken into account in assessing general damages. However, I do not accept that the help the claimant was providing before the surgery crossed into the territory of recoverable loss envisaged in Lowe v Guise. Without belittling what the claimant did at the time of her surgery, I do not believe that this represents a real identified need for services rather than the normal give and take of family life."

The care required by the deceased's young children is qualitatively much closer to the care provided by Mr Lowe to his disabled brother than it is to the help described by Yip J in the *Welsh* case, and therefore, I do not consider it appropriate to adopt the approach described by Yip J. However, I do note that this approach achieves an outcome consistent with the outcome advocated in *Daly*. I turn now to consider the proper valuation of this claim in this case along the lines suggested in *Lowe,* and in order to do so I must carefully consider the evidence given by both care experts in this case.

[74] Mrs McCarrick, the plaintiff's care expert, in her reports and evidence estimates that between 1 February 1972 and 18 May 1982 the amount of child care and ancillary work required which would have been provided by the deceased but for her injuries and which had provided by others amounted to 98 hours per week during the day being priced at a commercial rate with night care of 10 hours per day being charged at a sleeper rate (50% of the day rate). Between 19 May, 1982 and 18 May 1984, she estimates that the amount of child care and ancillary work required which would have been provided by the deceased but for her injuries and which had provided by others amounted to 32 hours per week, priced at a commercial rate.

From 19 May 1984 until 18 May 1985, 16 hours per week at a commercial rate is Mrs McCarrick's estimate. This reduces to 10 hours per week between 19 May 1985 up until 18 May 1986. This reduces further to seven hours per week from 19 May 1986 until the death of the Deceased on 26 January 1988.

[75] Mrs Baird, the defendant's care expert in her reports and evidence allows 10 hours per day at the agreed commercial rate with 10 hours per night at the agreed sleeper rate for the period between 1 February 1972 and 29 May 1972. Between 30 May 1972 and 23 August 1972, she allows 63 hours per week day time care charged at the agreed commercial rate but she does not allow for any specific night time care. Between 24 August 1972 and 22 February 1974 she allows 56 hours per week day time care charged at the agreed commercial rate with no specific night time care. Between 23 February 1974 and 13 October 1976 she allows 42 hours per week day time care charged at the agreed commercial rate with no specific night time care. Between 14 October 1976 and 13 October 1978 she allows 35 hours per week day time care charged at the agreed commercial rate with no specific night time care. Between 14 October 1978 and 13 October 1980 she allows 28 hours per week day time care charged at the agreed commercial rate with no specific night time care. Between 14 October 1980 and 13 October 1982 she allows 14 hours per week day time care charged at the agreed commercial rate with no specific night time care. Between 14 October 1982 and 13 October 1984 she allows 7 hours per week day time care charged at the agreed commercial rate with no specific night time care. Between 14 October 1984 and 26 January 1988 she allows 5 hours per week day time care charged at the agreed commercial rate with no specific night time care.

[76] Mrs McCarrick's estimates of care and ancillary work are explained to some extent in section 4.2 of her report dated 11 September 2018. The relevant portion of the report is set out between page 233 and 237 of the trial bundle. In essence, what Mrs McCarrick has done in relation to the period up to 18 May 1982 is to assume 14 hours day time care and ancillary work per day and 10 hours night time where the carer needs to be available to meet the night time care needs of the children. This equates to 98 hours day time care per week. She has then apportioned the 98 hours between various tasks: 21 hours for meal preparation; 14 hours for additional housekeeping; 10.5 hours for laundry and ironing; 21 hours for personal care of the children; 2.5 hours for homework; 2 hours for activities; 5 hours for accompanying the children to school, appointments and activities; 10.5 hours for grocery shopping; 1 hour for financial management; 3.5 hours for discipline; and 7 hours for emotional support.

[77] Initially, Mrs McCarrick had only included the night time sleeper rate allowance for the period up the end of May 1972 when the deceased was in hospital. However, she later extended the night time care up until 18 May 1982. It is recorded in the joint minute of the experts' meeting that took place on 3 March 2021 that Mrs McCarrick considered that this extension of night time care was appropriate on

the basis that "if the children were out of the house Mrs Deery would have been unable to go out and get them and that the older children would have had to look for them." See page 8 of the joint minute dated 3 March 2021. When Mrs McCarrick was specifically questioned about her justification for extending the period for night time care up to 18 May 1982 she justified this by reason of the younger children in the house having bed wetting problems which would have meant bed sheets had to be changed at night. It was pointed out to her that this issue was not mentioned in 4.2 of her report, nor was it offered as a justification during the experts' meeting. However, Mrs McCarrick was able to point to section 3.1.6 of her report where this problem is specifically referred to. See page 225 of the trial bundle.

[78] Mrs McCarrick's cut-off date of 18 May 1982 for the 98 hours per week of care and ancillary work is based on her assumption that the burden which would have otherwise been borne by the deceased would have lessened when her youngest child reached the age of 11. As indicated above, there is an estimated reduction to 32 hours per week but this estimate is not explained or apportioned into discreet tasks or functions. The further reduction to 16 hours per week from 19 May 1984 is explained on that basis that from that date there were only three children in the house under the age of 18. Again, this estimate is not explained or apportioned into discreet tasks or functions.

[79] The further reduction to 10 hours per week from 19 May 1985 is explained on that basis that from that date there were only two children in the house under the age of 18. Again, this estimate is not explained or apportioned into discreet tasks or functions. The further reduction to seven hours per week from 19 May 1986 is explained on that basis that from that date there was only one child in the house under the age of 18. Again, this estimate is not explained or apportioned into discreet tasks or functions.

[80] During cross-examination of Mrs McCarrick, it became very obvious that the division of the 98 hours of day time care and ancillary work into various tasks and functions was in essence guess work by Mrs McCarrick based on her own experience as a housewife and mother with a background knowledge of living in the Creggan estate. It became clear that she had not probed the family members she had interviewed in any detail to obtain concrete histories about the specific tasks and activities to which she had attributed a specific number of hours per week during the period up to 18 May 1982. The breakdown provided by Mrs McCarrick is to a large extent speculative and I again point to what I said in paragraph [31] of this judgment.

[81] Further, Mrs McCarrick's assessments and estimates seem to ignore the fact that before the events of Bloody Sunday but after the death of the deceased's husband, Margaret, the eldest daughter of the family, had left school to help her mother look after the younger children and run the house. Even if Bloody Sunday had never occurred, Margaret and in turn the younger daughters would have

inevitably carried a substantial portion of the burden of childminding and homemaking. The deceased's presence at the demonstration on Bloody Sunday with Helen Deery would very strongly suggest that another person was looking after the younger children on that Sunday afternoon. For these reasons, I simply cannot accept the assessments and estimates proffered by Mrs McCarrick as expert evidence.

[82] Mrs Baird's main care report is dated 13 September 2018. The section in respect of the retrospective loss of childcare and homemaking contribution is also section 4.2 and this is set out at pages 281 and 282 of the trial bundle. I note that Mrs Baird's assessments and estimates are to some extent influenced by the research carried out by David Piachaud from the London School of Economics who published a pamphlet "Round About Fifty Hours a Week – the time costs of children" (1 May 1987). Section 2.5.1 of Mrs Baird's report sets out what could best be described as a brief socio-economic history of the Creggan estate in the early 1970s. The remainder of section 2.5 of the report provides a detailed account of Deery family life following the events of Bloody Sunday. When one considers the specific assessments and estimates provided by Mrs Baird for the period between Bloody Sunday up to the death of the deceased in January 1988, as set out in sections 4.2.1 to 4.2.4 of her main report (pages 280 and 281 of the trial bundle) it is clear that the same general criticisms as were levelled against Mrs McCarrick can be levelled against Mrs Baird. Mrs Baird is to a large extent relying on her personal knowledge of the area and the times, combined with her own experiences, with some support for her opinions being gleaned from the research carried out by David Piachaud.

[83] This research is described in page 8 of the joint minute of the experts dated 3 March 2021. The first thing to note is that there is a discrepancy about the date of publication of the research. In page 8 of the joint minute it is stated that the research was published in 1984 whereas in Mrs Baird's main report, the date of publication is given as 1 May 1987. The research consists of Mr Piachaud reporting "on the results of questionnaires given to parents in an attempt to ascertain the average amount of time spent by parents on childcare of small children. Before this time, it would appear that there had been little work done on childcare and it was hoped that the results would help form Government future policy."

[84] Mr Piachaud's research involved looking at nine different tasks and functions related to childcare. These were:

(a) Getting children up and dressed;
(b) Taking children to the toilet and changing nappies;
(c) Taking children to nursery or school and collecting;
(d) Extra time for shopping;
(e) Extra time for meals – cooking, serving, supervision and washing up;
(f) Washing and bathing children;
(g) Putting children to bed;

(h) Extra time for washing and ironing;
(i) Clearing up and cleaning up after children.

[85] The research revealed that on average 432 minutes per day (50 hours per week) was spent on these tasks. For children under two years old, the average was 494 minutes per day (57.6 hours per week), with mothers undertaking the bulk of these tasks. In the joint minute it is recorded that Mrs McCarrick was of the opinion that the study did not make reference to any child parent ratios and, therefore, the hours quoted in this study cannot be transferred or applied to every situation in particular to a single parent with 14 children. In my opinion, Mrs McCarrick's comments on relevance to this research to the present case are clearly justified.

[86] Mrs Baird provides no breakdown of the weekly hours allowed by her and her assessment of the total weekly hours allowed during the various periods contained in her report, although related to the increasing maturity of the children and the fact that the care burden of looking after the younger children would have been shared in any event by the older children, is educated guesswork and nothing more than this. Her estimates are just as speculative as Mrs McCarrick's although the factual foundations upon which she bases her estimates appear to be sounder. Having carefully considered both experts' reports and evidence, I am driven to conclude that I am unable to accept either speculative opinion in its entirety because to do so when would call into question the integrity of the judicial process.

[87] If I am unable to accept the opinion of either expert because I consider both opinions to be based on an unacceptable amount of guesswork and speculation, how am I to assess in money terms the loss which clearly did occur in this case as is evidenced by the fact that the defendant's care expert acknowledges that such a loss did occur? I must recognise that any individual assessment by me involves an element of speculation on my part and I must be careful to ensure that such speculation is kept to a minimum so as not to damage the integrity of the judicial process.

[88] Doing the best that I can, I consider that a sleeper rate for night time care is clearly justified in the period that the deceased was in hospital and that the need for night time care, having regard to the number of children and the issue of bed wetting continued for some time thereafter. The suggestion that night time care was needed up until the youngest child reached the age of 11 does not bear scrutiny as there is no specific history of problematic bed wetting up to that age. I am prepared to allow a night time care sleeper rate up to the time when the youngest child was five years old which would be 18 May 1976.

[89] In relation to day time care, whilst I accept that looking after 14 children as a single parent could easily be described as a full-time unremitting job, the assessment of 98 hours per week means that no allowance whatsoever is made for the deceased having any time to look after herself, such as eating, washing or toileting. Further,

the plaintiff's figures up to May 1982 do not take any account of the fact that the care burden would have been shared in any event as a result of Margaret leaving school after her father died to help her mother look after the younger children and that after September 1975 all the young children in the house would have been out at school for a part of the day. Having carefully considered all the evidence, I think it is appropriate to reduce the plaintiff's estimate of 98 hours per week by one third to 65 hours per week up to 31 August 1975 to account for the fact that the care burden would have been shared in any event by the eldest children.

[90] Between 1 September 1975 and 31 August 1982 further reductions in the care burden are clearly warranted because all the younger children would have been at school and all the children would have been maturing and would not have needed as much hands-on care. However, account must be had to the fact that the children would not have been as school during school holidays and some care provision must be allowed for this. Therefore, for the year 1 September 1975 to 31 August 1976, I make a further reduction of one quarter, which results in an allowance of 49 hours per week. Between 1 September 1976 and 31 August 1982, I make six annual reductions of five hours per year so that by 1 September 1982 the assessed weekly allowance is 19 hours. This is to take proper account of the fact that the children continued to mature and the assistance of the older children would have been available in any event.

[91] From 1 September 1982 until 18 May 1984, I assess the appropriate weekly allowance in terms of hours as amounting to 19 hours per week. From 19 May 1984 up to the date of the death of the deceased, I assess the appropriate weekly allowance as amounting to seven hours per week. Both these reductions are based on the continued maturity and self-sufficiency of the children remaining in the house. It will be for the forensic accountants to provide an amended schedule of costings based on these estimates of hours. The care experts appear to have been able to agree on the appropriate rates for the valuation of commercial care during the period between 1 February 1972 and 26 January 1988 and if this is correct then these rates should be used for the purposes of the necessary calculations. For the avoidance of doubt, I consider that the night time sleeper rate should be costed at 50% of the associated day time rate and that when the appropriate calculations have been performed, a 25% reduction from the overall final figure should be made to account for the fact that the care was provided by family members, as opposed to professional carers. No further reductions should be made to account for the provision of any portion of the care by family members under the age of 18 years.

[92] In summary, the compensatory payment in this case for general damages for pain, suffering and loss of amenity including psychiatric injury and injury to feelings and aggravated damages for the increased and enduring injury to feelings suffered by the plaintiff will be in the sum of £250,000. This sum shall attract interest from date of service of the writ (16th June, 2014) at the usual rate. The special damages award will consist of £17,028 for the cost of care provided to the deceased plus the

agreed calculation in respect of the loss of caregiver's facility. Both these sums will be subject to further adjustment for interest on past losses which the forensic accountants should be able to agree. I understand that there is also an agreed sum in respect of travel costs and I would ask the parties to confirm this. I also understand that there may be an outstanding issue about the size of an ex gratia payment made by the defendant at a much earlier stage and the extent to which this payment should be taken into account, bearing in mind what the value of this payment would be at this stage. I would request that all remaining calculations should be finalised within seven days and that a schedule from which the size of the final decree to be entered in this case can be easily identified.

[93] The plaintiff is entitled to his costs and the court makes an order for taxation of the plaintiff's costs in default of agreement.