Neutral Citation No. [2011] NIQB 48 | *Ref:* **GIL8193**

Judgment: approved by the Court for handing down | *Delivered:* **08/06/11**
*(subject to editorial corrections)**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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QUEEN'S BENCH DIVISION

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BETWEEN:

MM, a minor acting by
CM, her mother and next friend

Plaintiff;

-and-

WESTERN HEALTH AND SOCIAL SERVICES BOARD

Defendant.

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GILLEN J

Introduction

[1] The minor plaintiff in this case is a profoundly disabled child with cerebral palsy resulting in, inter alia, severe learning difficulties, spastic quadriplegia, visual impairment, moderate right sided hearing loss, feeding difficulties, epilepsy and microcephaly. She is therefore a vulnerable child who is unable to protect herself from danger or outside sources of exploitation and requires 24 hour care and supervision. She has no meaningful verbal communication. The cerebral palsy arose as a result of treatment administered to the plaintiff's mother at her birth in October 1994. Liability in negligence has been admitted by the defendant.

Background

[2] Mr Stitt QC who appeared on behalf of the defendant with Mr McAlinden and Mr McNulty QC who appeared on behalf of the plaintiff with Mr Coyle, have responsibly spent many hours negotiating in this case in an attempt to find a settlement. They have largely been successful in their endeavours save for one area that now comes before the court for determination.

Case Management

[3] Case management of a patient is a concept that is increasingly coming under consideration in catastrophe cases. It is described in Butterworths Personal Injury Litigation Service volume 1 at paragraph 613 in the following terms:

> "In the more serious cases it might be necessary to appoint a case manager who may undertake one or more of the following roles:
>
> - implementation and management of the claimant's care regime;
> - the hiring, firing and disciplining of carers;
> - liaising between the claimant and different health care professionals (such as medical experts, physiotherapists, special and language therapists, carers, occupational therapists, etc);
> - ensuring that the claimant's care needs are being met and recommending any changes to the existing system; and
> - management of the claimant's financial affairs and ensuring entitlement to state benefits."

[4] The more structured the plaintiff's environment – such as residential accommodation – the less likely it is that a case manager will be justified (see Thrul v. Ray [2000] PIQR Q44.)

[5] It is also vital that careful scrutiny be kept on the cost of any case management to ensure that the same is reasonable and accords with any previous estimate given. See O'Brien v. Harris [22 February 2001, unreported QBD] in which Pitchford J limited the amount claimed for past rehabilitation and case management costs because the sums claimed significantly exceeded the estimates given without adequate explanation.

[6] It is common case that there are relatively few case managers working in this field in Northern Ireland. Ms McReynolds RGN RMN BSc (Hons), the care expert retained on behalf of the plaintiff, reported that she has undertaken the task for the first time in another case of a severely injured patient in the last year. When Ms McReynolds reported in the instant case in May 2009 (before she had actually undertaken the task of case manager), she had calculated the estimated costs of care management as follows:

"**1st year**

£85.00 per hour x 81 hours	£ 6,885
£40.00 travel x 3 hours x 18 visits ..	£ 2,160
£00.45 x up to 150 miles x 18 visits	£ 1,215
	£10,260

Subsequent years

£85.00 per hour x 60 hours	£ 5,100
£40.00 travel x 3 hours x 14 visits ..	£ 1,680
£00.45 x up to 150 miles x 14 visits	£ 9,045
	£ 7,725"

[7] Since that date, by virtue of taking on the role of a case manager of a young man similarly profoundly disabled to the plaintiff in this case, she had become much more aware of what was involved. She listed a plethora of tasks–

- Meeting with the family and ascertaining their wishes.
- Meeting with the solicitors on behalf of the plaintiff.
- Meetings with the Master in the Office of Care and Protection.
- Drawing up appropriate costs for the Master in the Office of Care and Protection.
- Opening a bank account and managing the care of the money of the patient.
- Recruitment of staff. This involved employing personnel to help her draw up job applications/job descriptions/contracts of employment/considering fair employment issues/advertisements/short listing and interviewing staff over 2 days.
- Letters of acceptance and regret for staff.
- Liaising with social workers/district nurses/consultants/occupational therapists/physiotherapists involved in the case.
- Purchasing aids and equipment.
- Liaising with architects and builders in arranging housing accommodation.
- Pursuant to a European Directive, ensuring appropriate training in management and handling of patients on a yearly basis. Training has now become a vital factor which each person employed to care for a patient has to undergo each year.
- Monitoring visits to the patient's home on a spot check basis.
- Liaising with an accountant to arrange a payroll for carers.

- Crisis management.
- Miscellaneous administrative telephone calls.

[8] Her evidence was that she was now satisfied in light of her experience that the figures she had put forward in 2009 were much too modest. It was her calculation that a case manager would require 16 hours per month in the initial year in order to set the whole system up and that thereafter 12 hours per month were required to keep the system working. The figures for the first year would therefore amount to £16,800 and for the subsequent years £12,600.

[9] One matter of dispute between the parties in the case was that of alleged additional outlays. It was agreed that the case manager was responsible for discharging the following outlays :

- Payroll system at £500 per annum.
- Insurance at £500 per annum.
- Training by an expert. This would cost £1,800 i.e. £200 per carer for the first year and £1,000 each year thereafter.
- Recruitment/advertising/interviewing at £2,000 for the first year in order to set the system up and £1,000 per annum thereafter to deal with employment churn when members of staff invariably leave from time to time.

[10] It was Ms McReynolds case that these outlay figures i.e. £5,000 in first year and £3,000 per year thereafter should be paid in addition to the case management estimates set out in paragraph 6 of this judgment. Ms McReynold's evidence was that in the course of her duties as a professional witness dealing with such care cases over the last 2 years, she had regularly agreed settlements with other care experts on the basis that 15% of the overall cost of care should reflect the case management tariff and in addition there should be figures for advertising, training allowance, payroll, subsistence, criminal record check and insurance.

The defendant's case

[11] Ms Craughwell was a care expert called on behalf of the defendant. She was a well qualified paediatric ward sister whose caseload involved children with cerebral palsy. She is employed by Carnmoney Care Consultancy. She had never been a case manager but she has coordinated services for children with cerebral palsy. Moreover she was well aware of the policy adopted by Carnmoney Care Consultancy in case managing various cases.

[12] It was Ms Craughwell's evidence that in a large number of cases in the Republic of Ireland, the approach to case management cost had been to fix an upper limit of 15% of the overall care costs as the appropriate tariff. This

would include incidentals such as advertising, training allowance, payroll, subsistence, criminal record checks and insurance.

[13] Mr Stitt submitted that Ms Craughwell's approach drew strength from a judgment of Coghlin J in Regina McKenna by her father and next friend William McKenna v. Rosemary Connolly and Others [2008] NIQB 69. That also was a case where the plaintiff had suffered devastating injuries rendering her unable to speak or enjoy an independent existence. The general damages in that case were £300,000.

[14] Dealing with the issue of care management, Coghlin J said at paragraph 22:

> "It seems to me that this is an area of the case in which it is particularly important to bear in mind the need to focus upon the particular circumstances of the individual plaintiff. Both Mr & Mrs McKenna expressed themselves as entirely satisfied with the performance of the current local team of carers . . . It is clear that the major task of setting up the care system was completed some years ago by Mr McKenna and that the current management of the carers' payroll was carried out on a voluntary basis by his sister who is employed full time as an office manager for a forestry company . . . I am not persuaded that it is reasonable in the circumstances of this case to provide for both the care manager and a team leader and I am inclined to the view that the relevant functions of both such positions could be satisfactorily discharged by a local person, quite possibly one of the present carers. I accept that such a person would have additional responsibilities and it seems that such duties would be adequately compensated by a sum representing some 15% of the total annual care salaries and national insurance contributions. As Mr Catlin (*the care expert on behalf of the plaintiff)* has advised such a percentage would include incidentals such as advertising, training allowance, payroll, subsistence, criminal record checks and insurance."

[15] I pause to observe that Ms McReynolds gave evidence that she has since spoken to Mr Catlin who indicated that when he made this concession about the inclusion of incidentals etc he was "not used to case management".

[16] Ms Craughwell calculated that 10 hours per month at a yearly cost of £10,200 in the first year and 7 hours per month thereafter at a yearly cost of £7,140 would be sufficient, these figures to include the additional outlay.

[17] The parties had helpfully indicated to me that 15% of the agreed overall care costs exclusive of outlay in the instant case would amount to £14,527. 12% of the yearly care costs, a figure suggested by the defendant for the second and ensuing years, would amount to £11,622 per annum.

[18] Finally Mr Stitt drew my attention to the case of Sarwar v. Kamran Ali [2007] EWHC 1255 where Lloyd Jones J dealt with the cost of a care manager in England who was expected to oversee the management of a claimant's care regime who had suffered severe spinal and brain injuries. His care management needs were greater than those typically experienced by a tetraplegic because he suffered from memory problems which impacted on his problem solving abilities. The trial judge made provision for 125 hours in the first year (approximating to 10.5 hours per month) and 105 hours thereafter (approximating to 8.7 hours per month).

Conclusions

[19] I share entirely the view of Coghlin J that it is important to bear in mind the need to focus upon the particular circumstances of an individual plaintiff. Case management will clearly differ from case to case and therefore it is difficult to set one standard for every case. Moreover it does seem to me that, as in this case, the setting up and resourcing of services in the first year is going to require greater input than the "ticking over" procedures necessary in subsequent years.

[20] Equally it is important that wherever possible the court should embrace any generally approved market place practice in assessing such management costs whilst applying to any such approved practice the test of proportionality and common sense. Such a practice will lend itself to simplicity, transparency and consistency in arriving at figures and will aid the process of resolution without the need for a court hearing. However such practice must accord with market place reality and it is important that it is crosschecked with actual projected figures in the particular case under consideration to ensure it is fair and proportionate.

[21] Thus in most cases, the McKenna case being a genuine exception, the outlays are clearly going to be higher in the initial year. In this year the whole system will have to be set up de novo. In the present case setting up a staff of nine together with all the other tasks is going to be difficult, onerous and time consuming for any case manager who will require to introduce the skills of other experts to assist. Insurance and payroll costs will remain consistent

throughout the later years, but recruitment costs and training costs etc. will obviously be higher in the initial year. Hence understandably the parties have agreed differing figures for the first and ensuing years.

[22] One can never be precise about the projected number of hours required in any given case, particularly where the experts differ as in this instance. However, given her recent experience as a case manager, I am inclined to the view that the list of tasks adumbrated by Ms McReynolds point to the likelihood that her suggested hours - albeit perhaps towards the top end of the spectrum – are more likely to be accurate than those of Ms Craughwell who has not performed the task at all. I have crosschecked those figures against the general practice in the Republic of Ireland of agreeing a percentage for the overall care costs — up to a maximum of 15% - exclusive of outlay for case management settlements.

[23] I have determined that the market place practice suggested by Ms Craughwell should not apply at least to the first year because 15% of care costs to include the outlay would not reflect the reality of the actual cost that I am satisfied would be incurred. Making a small reduction in the hours suggested by Ms McReynolds, I have concluded that 15% of the agreed care costs exclusive of the agreed outlays for the first year should be awarded in the instant case for year one together with the outlay.

[24] So far as the ensuring years are concerned, I believe that a figure of 15% of the agreed care costs inclusive of outlay reflects the costs suggested by Ms McReynolds, again with a small reduction, and is fair and proportionate. I do not consider the defendant's suggested figure of 12% inclusive of outlay would be sufficient. 12% plus outlay might be marginally over generous. Coincidentally this reflects the approach taken by Coghlin J in McKenna's case at least for the subsequent years.

Team Leader

[25] The plaintiff, through the evidence of Ms McReynolds, advanced the argument that a team leader was necessary in addition to a case manager. It was submitted that a team leader was necessary to deal with staff matters such as:

- Duty rotas.
- Days off.
- The shift system.
- Compassionate leave.
- Ensure the smooth running of staff relations.
- Crisis management on the spot.

[26] Whilst I do not rule out circumstances in which a team leader would be necessary in addition to a case manager, I am not persuaded it is required in the presence instance. I note that Coghlin J came to the same conclusion in the McKenna case. I believe that Ms Craughwell has commonsense on her side when she indicates that in the present case a system ensuring that the last person on the shift does not leave before taking steps to be satisfied that someone else has taken over the next shift would be sufficient crisis management outside the remit of the case manager. Already in the costs for care there is one hour per day for family time and that should give the family sufficient opportunity to assess what is going on and to alert the case manager to any crisis looming. The role of the case manager includes visits to assess the carers from time to time and that also should alleviate any problems. In all the circumstances, therefore, I have come to the conclusion that the relevant functions necessary in this case can all be carried out by the care manager. I make no allowance therefore for a team leader.