Neutral Citation Number: [2023] EWHC 2970 (KB)

Case No: E90SE156

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
SHEFFIELD DISTRICT REGISTRY

Sheffield Combined Court Centre
50 West Bar
Sheffield

Date: 22 November 2023

Before :

HIS HONOUR JUDGE ROBINSON sitting as a Judge of the High Court

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Between :

WNA	**Claimant**
- and -	
NDP	**Defendant**

- -
- -

Adam Weitzman KC and Patricia Leonard (instructed by **Irwin Mitchell LLP**) for **The Claimant**

James Todd KC (instructed by **DWF LLP**) for **The Defendant**

Hearing date: 18 September 2023

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Approved Judgment

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This judgment was handed down by the Judge remotely by circulation to the parties' representatives by email and release to The National Archives. The date and time for hand-down is deemed to be 10.30am on 22 November 2023.

His Honour Judge Robinson:

Introduction

1. On 20 February 2020 I gave judgment on the preliminary issue of liability in this case. The relevant facts can be shortly stated. At about 9.30 pm on 24 September 2016 the Claimant was the front seat passenger in a Ford Fiesta motor car ("the Fiesta") being driven by the Defendant, who at the time was also her boyfriend. She was wearing her seatbelt. Two other persons were passengers in the rear seats. The Defendant was negotiating a left hand bend in the road when he was faced with an on-coming car. I found on the evidence that he lost control of the Fiesta. The Fiesta overturned and ended up on its roof. The driver of the on-coming car did not stop and has never been traced.

2. I found the Defendant to be at least partially to blame, and hence liable to the Claimant for the catastrophic injuries she sustained. I did not apportion liability between the Defendant and the driver of the untraced vehicle because, as I observed in my liability judgment at [9]:

> "It is trite law that even if the Defendant is only partly to blame for the accident, the doctrine of joint and several liability means the Claimant will be able to recover 100% of the value of her claim for damages from the Defendant, via his insurers."

3. Following judgment on liability, the parties have been investigating the value of the claim. The Claimant was born on 27 June 1987. She was aged 29 at the date of the accident and is now 36 years old. She suffered catastrophic injuries as a result of the accident. Briefly stated she was found to have sustained a comminuted fracture of the C6 vertebrae. The spinal cord was damaged beyond repair such that she is now tetraplegic. She has some limited movement in her upper limbs. She has full litigation capacity.

4. The trial of quantum was listed for 12 days starting on 18 September 2023. The parties are to be commended for being able to reach agreement:

   (1) On the form of the award of damages, namely a lump sum and a Periodical Payments Order (PPO) providing for annual Periodical Payments (PPs) in respect of care and case management index linked, in the usual way, to the 80th centile of the relevant wage inflation indices published by the ONS, which in this case is ASHE 6135 and 6136.

   (2) The figures for the lump sum and the initial annual PP, namely £6.25m and £325,000 respectively.

   (3) That the lump sum award shall be a provisional award to reflect the risk of a syrinx developing. If that does occur, it is agreed that it cannot be treated, and the Claimant may return to Court to seek further damages.

5. I am grateful to Counsel for their extremely helpful skeleton arguments and for the collaborative manner in which the outstanding issue between the parties has been presented before me. This has included Mr Weitzman KC taking me through the various authorities and statutory provisions pointing out not only the passages upon which he seeks to rely but also those upon which Mr Todd KC seeks to rely.

6. The issue is phrased by Mr Weitzman in his skeleton argument as "how most appropriately to deal with the problem of double recovery" in respect of damages for the cost of future care.

7. The issue arises in this way. The Claimant's Lump Sum award will be placed in a Personal Injury Trust. As such, that sum is left out of account when assessing her means for the purpose of determining her entitlement to state funding for the costs of care. The same is true of the annual PPs in respect of care and case management. That was essentially the issue in *Sowden v Lodge* [2005] 1 WLR 2129 (CA) to which both Mr Weitzman and Mr Todd referred. I shall refer *Sowden* again below.

8. It is by no means certain that the Claimant will ever have recourse to seeking state funding in respect of the cost of her care. However, there is insufficient or no material before me which would enable me to find as a fact that the Claimant will never apply for state funding for her care, a finding which has been made in other cases. Accordingly, the possibility that at some point in the future the Claimant will apply for state funding in respect of care cannot be ruled out. Note that (as the law stands at present) it is only state funding for the cost of care that is in issue. There is no state funding for case management. The cost of that must be met from the Claimant's funds.

9. It is agreed that the relevant order in this case will include a provision to deal with this issue, probably in the form of an appropriate undertaking. It is agreed that the Claimant will not apply for state funding in any one year until the annual PP in that year has been used up. Further, in a witness statement dated 13 September 2023 the Claimant, who I am pleased to say was in Court during this hearing, said:

> "I accept that if I need any top up of my care because all of my money from my periodical payment has been used up then I will need to apply for statutory top up. I have no desire to keep any statutory funding that I do not need for my care and have not used from my top up. I will annually repay any statutory funding which is not used for my care. I agree that if there is any excess money then I am happy to enter into any arrangement which the court thinks appropriate to ensure that the required repayments of statutory funding are made".

10. The parties are agreed on a mechanism to be employed in the event that the amount full amount of state funding is not used and the state funder, for whatever unlikely reason, declines to accept repayment of that sum or, which I find to be extremely unlikely, the Claimant declines to make the repayment.

11. The issue between the parties is easy to state and arises only if the cost of care and case management exceeds £325,000 in any individual year. The working assumption is that the cost of case management will easily be met from the annual PP of £325,000 and only the additional costs of care will be sought from state funder(s). The various examples given by the parties do not, for the sake of simplicity, take account of the fact that the amount of the PP is likely to increase year on year because it is linked to the relevant wage inflation indices of the ASHE published by the ONS namely, in this case, 6135 and 6136. Accordingly, the annual figure of £325,000 is used throughout.

12. The Claimant's position is that the accounting process should be conducted on an annual basis. Thus if, in any particular year the Claimant does not spend all of the £325,000, the surplus is hers to do with as she pleases.

13. The Defendant's position is that the payment of PPs is in the nature of a running account. Thus, say in year 1 the Claimant spends only £300,000 on care and case management. There is a surplus of £25,000. If in year 2, the cost of care and case management is £380,000, the Claimant will require a state funded top up payment in respect of the care element. But in what amount? The Claimant says £55,000 being the difference between the PP of £325,000 and the actual cost. The Defendant says that before the Claimant applies for state funding, she must first utilise the previous year's surplus of £25,000 before applying for state funding of the balance of the cost, being £30,000.

14. Moreover, argues the Defendant, the "running account" principle means that the aggregate of surplus moneys not spent on care and case management in previous years falls to be accounted for in any future years where there is a shortfall between the PP of £325,000 and the actual cost of care and case management. Thus, if in years 1 to 5 inclusive there is a surplus of £25,000 per annum, the aggregate surplus is £125,000. If there are then three successive years where the cost of care and case management exceeds £325,000 by £20,000 per annum, the Claimant must utilise £60,000 from the accumulated surplus of £125,000 and so on. Only when the accumulated surplus is exhausted may the Claimant once more apply for state funding "top up" to meet any shortfall between the PP and the actual costs of care. As indicated above, the examples all assume that the cost of case management is

easily paid for out of the £325,000 PP so the shortfall is purely in respect of care.

15. I have mentioned already that the Claimant has full litigation capacity and capacity to manage her own financial affairs. Therefore, this is not a case where the Court is being asked to approve a proposed settlement in accordance with the procedure in CPR Part 21. That said, I agree with the observations of the editors of *Kemp & Kemp: The Quantum of Damages* at para 23-042, which was brought to my attention by Mr Todd and agreed by Mr Weitzman:

> "In the ordinary way, where the claimant is a protected party, the court needs to approve the settlement. Any PPO settlement for a claimant with capacity will invariably be converted into a court order and the court is arguably, to some extent at least, also approving the settlement by making the court order."

The Law – Double Recovery

16. Unsurprisingly both Counsel agree on the law relating to double recovery as it has developed through the cases.

17. Put shortly, and dealing with cases where a Claimant seeks compensation from a tortfeasor in respect of personal injuries and consequential losses, it is trite law that a Claimant can only be compensated once in relation to any head of loss. If the tortfeasor pays full compensatory damages in respect of the relevant head of loss, the Claimant cannot seek assistance from the State in respect of that head of loss. Both Counsel referred me to the well-known dictum of Lord Bridge in *Hodgson v Trapp* [1989] 1 AC 807:

> "There could hardly be a clearer case than that of the attendance allowance payable under [the relevant Act of Parliament] where the statutory benefit and the special damages claimed for cost of care are designed to meet the identical expenses. To allow double recovery in such a case at the expense of both taxpayers and insurers seems to me incapable of justification on any rational ground."

18. I propose first to look at state funding, then to consider some of the case law concerning double recovery, and how the courts have sought to deal with this issue.

Statutory Funding Provisions

19. It is because there is assistance available from the State and other sources that the spectre of double recovery arises in the first place. Mr Weitzman took me through the relevant statutory provisions, but also made refence to the dictum of Roskill LJ (as he then was) in *Bowker v Rose* (1978) Times 3 February (also referred to in *Hodgson v Trapp* at pages 821H to 822A) where the point was made that there are other sources of relevant assistance:

> "[T]he questions that arise can never be determined in the abstract. Each must depend on the terms of the particular contract, pension scheme, charitable benefaction or statute governing the benefit conferred."

20. Funding from local authorities is governed by the Care Act 2014, as supplemented by the Care and Support (Direct Payment) Regulations (SI 2014/2672). In the case of a person with relevant capacity, the amount and frequency of payments will be set out in the care plan under Section 25. Mr Weitzman submitted, and I accept, that the combined effect of this legislation is that the Claimant's entitlement to direct payments must be reviewed at least annually (regulation 7) and must be repaid if not used for care – Section 33(5) and (7) of the 2014 Act.

21. Relevant funding is also available from the NHS by way of direct payments from a health body. The relevant statutory provision is the National Health Service (Direct Payment) Regulations (SI 2013/1617). Regulation 10 requires payments to be made into a "managed account" exclusively for the purpose of receiving funding and paying for the relevant service or services. Regulation 14 requires a health body to review the making of direct payments to or in respect of a patient "at appropriate intervals". In particular there must be a review at least once in the first three months of the direct payments being made and subsequently at intervals not exceeding twelve months.

22. Regulation 15 deals with repayment of direct payments:

"(1) A health body may require that part or all of a direct payment must be repaid to the health body, if satisfied that it is appropriate to require repayment having regard in particular to whether –

(a) the care plan has changed substantially;

(b) the patient's circumstances have changed substantially;

(c) a substantial proportion of the direct payments received by a patient, representative or nominee have not been used to secure services specified in the care plan and have accumulated;

(d) the direct payments have been used otherwise than for a service specified in the care plan;

(e) theft, fraud or another offence may have occurred in connection with the direct payments; or

(f) the patient has died …"

23. It seems to me to be significant that in the case of both payments from a local authority and from the NHS, the issue of direct payments is considered at least annually. This is not surprising. Care needs can change over time and regular review is in everybody's best interest. The provider of the direct payments needs to know if the funding continues to be sufficient or if circumstances have changed for the better so that a reduction in direct payments is appropriate. It is entirely appropriate that there be provision for repayment in the circumstances specified in Regulation 15. However, it should be noted that the power to require repayment is discretionary ("may require") and in the first two instances where repayment may be required, it is only in the event of "substantial" change, and in the third instance, the underspend must also be "substantial".

Case Law

24. Cases subsequent to *Hodgson v Trapp* have endorsed the principle that double recovery must be avoided wherever possible. In some cases, the object has been to seek to avoid the possibility of double recovery. In others the object has been to provide a mechanism for repayment in the event of double recovery.

25. Returning to *Sowden* the Claimant was held to be contributorily negligent to the extent of 50%, so that she would not recover sufficient money to pay for the care she required. In fact, she was being provided with state funded residential accommodation. It was held that there should be a reduction in the award of damages to avoid double recovery, although assessment of the amount was remitted back to the trial Judge to allow the Claimant to present evidence on the issue of "augmented" care. This is an example of the Court taking steps to avoid double recovery by adjusting the size of the award of damages.

26. The same result followed in *Crofton v NHSLA* [2007] 1 WLR 923 (CA), again referred to by both Counsel. There, the Claimant recovered 67.5% of the full value of the appropriate award of damages. The Judge made a deduction from the amount the Claimant would otherwise have received (itself reduced on account of the level of contributory fault) to take account of the value of state funding received by the Claimant. That decision was upheld by the Court of Appeal.

27. *Peters v East Midlands Strategic Health Authority* [2009] EWCA Civ 145 is an example of a case where steps were taken to avoid even the possibility of double recovery. The affairs of the severely disabled Claimant were being managed by a Deputy appointed by the Court of Protection. Before the Judge at first instance, the Deputy had offered an undertaking not to seek statutory funding for the Claimant's care and accommodation. The Judge refused to

accept such an undertaking. Before the Court of Appeal a modified undertaking was offered which involved the Deputy undertaking to notify the Court of Protection of the outcome of the current proceedings and to seek from the Court of Protection (a) a limit on the authority of the Deputy whereby no application for certain statutory funding can be made without further order of the Court of Protection and (b) provision for the Defendants to be notified in the event of such application being made. It was held that:

> "[65] … this is an effective way of dealing with the risk of double recovery in cases where the affairs of the claimant are being administered by the Court of Protection. It places the control over the deputy's ability to make an application for the provision of a claimant's care and accommodation at public expense in the hands of a court."

28. Mr Weitzman drew my attention to *R (Tinsley) v Manchester City Council* [2018] QB 767 where the validity of such an undertaking was questioned. Mr Todd also referred to the same case emphasising that whatever may have been said about the undertaking in *Peters* the underlying concern was the avoidance of double recovery. Mr Todd relied upon this passage from the judgement of Longmore LJ:

> "[26] It is, of course, the case that courts will seek to avoid double recovery by a claimant at the time they assess damages against a negligent tortfeasor. If therefore it is clear at trial that a claimant will seek to rely on a local authority's provision of after-care services, he will not be able to recover the cost of providing such after-care services from the tortfeasor."

29. The most recent example of a repayment mechanism is *CCC v Sheffield Teaching Hospitals* [2023] EWHC 1770 (KB), where reference was made to a "Peters Promise". *CCC* concerned a Claimant born with cerebral palsy. Although she was a child at the trial to determine quantum, she will always lack capacity to manage her affairs. Ritchie J at [180] dealt with the fact that the Claimant was in receipt of direct payments (from the NHS – see above) and apparently would or may continue to do so. He directed that:

> "[180] The sums received by the Claimant from the State for care by way of direct payments should be refunded to the Defendant annually on the day in December when the first PPO is made and annually thereafter. Otherwise the Claimant will receive more than she needs. I invite the Claimant to provide an undertaking to the court to refund the total sum received from the state for care on that date each year (a limited *Peters Promise*). I invite counsel to draft the undertaking. If the undertaking is not provided, I shall reconsider how best to account for the deduction simply by deducting the current annual payment. That would not take into account future changes and so would be rough and ready."

30. Having regard to the authorities to which my attention has been drawn, I accept the analysis of Mr Todd in his skeleton argument that what he refers to as "the primary solution" to the double recovery problem is to reduce damages to reflect likely receipt of public funding in the future. Of course, that requires there to be evidence upon which the Judge can make a finding on the balance of probabilities that such receipt is, indeed, "likely". Conversely, it may be possible to make a finding that such recourse is "unlikely". That was the position in *Freeman v Lockett* [2006] EWHC 102 (QB), relied upon by Mr Todd. In that case the Claimant had full capacity and recovered damages in full. Tomlinson J was able to find on the evidence that on receipt of damages for future care the Claimant would withdraw her application for state funding and would not reinstate it, thus no issue of double recovery arose.

31. In summary, the cases show that the common mechanisms to avoid double recovery are:
    (1) Reducing the once and for all lump sum.
    (2) Providing a mechanism for repayment to the provider of state funding.
    (3) Providing a mechanism designed to inhibit a claim for statutory funding, at least without some court oversight.

The PPO Mechanism

32. Mr Weitzman drew my attention to the relevant provisions of the Damages Act 1996 and the CPR.

33. The Damages Act 1996 does not specify the frequency of payment under a PPO. Section 2(1)(a) simply provides that:

> "(1) A court awarding damages for future pecuniary loss in respect of personal injury –
>
> (a) May order that the damages are wholly or partly to take the form of periodical payments, …"

34. Section 2(8) provides for variation of the amount of payment by reference to the retail price index:

> "(8) An order for periodical payments shall be treated as providing for the amount of payments to vary by reference to the retail prices index (…) at such times, and in such manner, as may be determined by or in accordance with the Civil Procedure Rules."

35. The reference to the RPI might suggest annual variation, but Section 2(9) provides that the order may include provision disapplying or modifying the effect of subsection (8). Whether that power is in practice used much or at all is not something that was canvassed before me.

36. Things are made clearer by Part 41 of the CPR:

> "41.8 – (1) Where the court awards damages in the form of periodical payments, the order must specify –
>
> (a) the annual amount awarded, how each payment is to be made during the year and at what intervals;
> (b) …
> (c) …
> (d) that the amount of the payments shall vary annually by reference to the retail prices index, unless the court orders otherwise under section 2(9) of the 1996 Act.

37. Thus it is clear in my judgment, that at least in the case of a PPO in respect of the cost of future care (and case management), the amount is calculated on an annual basis and in practice is usually paid annually in advance. The practice has arisen of using 15 October as the trigger date for the commencement of calculation of any variation in the amount payable under a PPO because that is the date on which the Office for National Statistics (ONS) usually publishes the Annual Survey of Hours and Earnings (ASHE) by reference to Standard Occupational Classifications (SOC). The index used most commonly in my experience is ASHE SOC 6115 relating to care assistants and home carers[1].

Discussion

38. I accept the submission of Mr Todd that the authorities show that the Court should be alert to double recovery; also that the Court should not just deprecate double recovery where it arises, but should actively intervene to prevent it.

39. Mr Todd also submitted that the fact of the annual nature of the payment of damages presents an opportunity for oversight to ensure that double recovery does not arise. That submission requires further consideration.

40. In my judgment, the key questions in cases where the annual Periodical Payment is for care and case management are these:
    (1) is the annual payment of money under a PPO to be treated as payment in respect of damages for care (and case management) generally, including future costs? or
    (2) is the annual payment of money under a PPO to be treated as payment in respect of damages for care (and case management) only for the year in respect of which it is paid?

41. If the payment is in respect of the costs of care (and case management) generally, then the argument for treating such PPs as amounting to a fund, any surplus of which is available to be used in future years only for that purpose, is strong.

[1] The proposed order in this case refers to SOC 6135 (care workers and home carers) and SOC 6136 (senior care workers). So far as I am aware, SOC 6115 continues to be published.

42. In considering whether the payment is to be treated as being referrable only to the costs in the year in respect of which it is paid, it is notable that the accounting period for PPs in cases such as this is the same as the accounting period for the assessment of state funding, namely annual.

43. Is the co-incidence of accounting periods significant? On the Defendant's case, what is required is an annual running account with any unspent surplus of an individual year's PP being set aside to be used in future years, if and when there is a shortfall.

44. In my judgment, that is too simplistic an approach and ignores the realities. Practical problems are easily identifiable:

(1) Is there a minimum annual amount of surplus to be taken into account, and, if so, what is it? I have in mind here the reference to "substantial" in the NHS Regulations.

(2) If there is no minimum amount, it means that sums of a few pounds or pence must be ring-fenced in case in the future, perhaps many years in the future, there is a shortfall.

(3) In a case such as this, where the Claimant has full capacity to manage her own affairs, is it proportionate to require detailed records to be kept perhaps for many years? If not, and the concept of annual accounting is rejected, is there a cut off point where any accumulated surplus may be spent as the Claimant wishes? If so, what is that cut off point? Six years or some other and if so what period? Mr Todd submits that the administrative burden on the Claimant is "slight". I am not so sure it is "slight" if the obligation to keep and retain accounts is life-long.

(4) Is the cause of the surplus relevant? What if, say, the reason is that suitable and sufficient staff were not available, so that the Claimant had to struggle on with inadequate care to meet her needs and had a frankly horrid time over the year. Would she be able to say "I have struggled and suffered over this year. I am going to treat myself to something lovely to compensate and I am going to use the money not spent on non-existent carers to do so"?

(5) In a similar vein, the PPs in this case are also in respect of case management, for which (at present) no state funding is available. What if the surplus is the result of an underspend on case management?

(6) On a practical note, is there an obligation to keep any surplus in an interest-bearing account and if so, is the interest to be counted as surplus to pay for care in future years?

45. There is also an anomaly in the "running account" process proposed on behalf of the Defendant in that it is only prospective and not retrospective. If there is no accumulated surplus at time when state funding is obtained, but in future years there is a surplus, why should that surplus not be paid retrospectively to the State? It is not proposed that it should, as I understand the Defendant's case.

46. The problem, if such it should be classified, with the avoidance of double recovery is that, in the case of once and for all lump sum awards in respect of care, rough and ready adjustments have to be made to guard against any prospect of double recovery which is established on the evidence. Precision is impossible. Mr Todd recognised this when he conceded in his skeleton argument that in such cases there "may be a blurring of the lines within a settlement figure" before going on to submit that "there can be no question that the periodical payment, and hence any unspent part of it, is and remains moneys that have been designed solely to meet care and case management costs".

47. In cases such as this one, with annual PPs paid to provide care (and case management) it is possible to achieve a much greater degree of accuracy if one looks at the issue on a year-by-year basis. There is coincidence of cost centre and accounting period. If in any one year the PP is not enough, in that Claimant spends all of the PP on care (and case management) but requires additional state funding, there is no double recovery provided that at the end of the year, any unspent element of state funding is repaid to the State. That is what is proposed in this case.

48. It must be acknowledged that Mr Todd's submissions were attractively and persuasively presented. But at the heart of his submissions is the single proposition that the annual payment may only be used for care and case management. I agree with that, subject to one crucial qualification. The annual payment may be used only for care and case management *within the relevant accounting period* which in this case is a single year.

49. Accordingly, for the reasons given above, in my judgment in this case the PPs are to be treated solely as damages relating to care (and case management) provided during the relevant year for which those services are provided. If the money is not wholly spent to meet the cost of care (and case management) provided during that year, there is no obligation to accumulate the surplus to pay for care (and case management) in subsequent years. This is a simple

straightforward solution that, in my judgment, is entirely in keeping with the ethos of a PPO, namely that the money paid to the Claimant is to be used to provide care (and case management) for the year in respect of which the annual PP is made.

50. It also follows that in respect of any surplus at the end of any particular year, the Claimant is at liberty to deal with it as she sees fit: *Wells v Wells* [1999] 1 AC 345 (HL) per Lord Clyde at p394H citing Lord Fraser in *Cookson v Knowles* [1979] AC 556, 577D:

> "It is for the plaintiff to decide how the award is to be applied. Whether he is proposing to invest it, or spend it, or more particularly, exactly how he is going to invest it or spend it does not affect the calculation of the award."

51. I leave it to Counsel to formulate the appropriate form of order and to consider whether any undertaking to deal with repayment to the state of any surplus of state funding is required.