Neutral Citation Number: [2013] EWHC 2263 (QB)
Case No. HQ11X02542

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London WC2A 2LL
10/07/2013

Before:

MR JOHN LEIGHTON WILLIAMS QC
(sitting as a Judge of the High Court)

Between:

KAY STANLEY ZAMBARDA
(Widow & Executrix of the Estate of ROBERTO ZAMBARDA deceased)

Claimant

-and-

SHIPBREAKING (QUEENBOROUGH) LIMITED

Defendant

Mr Harry Steinberg of 12 King's Bench Walk (instructed by Harminder Bains of Leigh Day) for the Claimant
Mr Patrick Limb QC of Ropewalk Chambers (instructed by Damon Burt of Plexus Law) for the Defendant
Hearing dates: 8, 9 & 10 July 2013

JUDGMENT

Mr John Leighton Williams QC:

1. This is a claim for damages brought by the claimant as dependant of her deceased husband under the provisions of the Fatal Accidents Act 1976 as amended and on behalf of his Estate under the provisions of the Law Reform (Miscellaneous Provisions) Act 1934.

2. The deceased, Mr Zambarda, was employed by the Defendant between 1966 and 1986. He regularly burned asbestos off pipes and the like and as a result contracted malignant mesothelioma from which he died on 14 September 2011 at the age of 70.7 years.

3. The Defendant has admitted that the deceased was negligently exposed to asbestos. On 21st November 2012, judgment was entered against for the Claimant on the issue of liability with damages to be assessed.

Background

4. Mr Zambarda was born on 8 January 1941. Mrs Zambarda was born on 24th February 1944. They were married in 1969. Their 5 children have all now left home. Most continue to live not far from the family home. Over the years Mr Zambarda had worked hard to support his family. They remain a close family.

5. For most of his life Mr Zambarda had been in good health. Sadly this has not been so for Mrs Zambarda who has complex medical problems. Prior to their marriage she had suffered from ulcerative colitis. In 1970, shortly after their marriage, she had to undergo a colectomy and

ileostomy since when she has had a colostomy bag. She has had numerous operations to refashion the ileostomy and to remove adhesions, and has a parastomal hernia. In recent years she has had further health problems. In May 2005, she underwent excision of a superficial melanoma on her right arm; in December 2009, she received steroid therapy for suspected polyymyalgia rheumatica; in September 2010 degenerative changes were noted in her lumbar spine with evidence of lumbar stenosis at L4/L5; on 25 October 2011, she underwent excision of a carcinoma of the right breast with axillary lymph node biopsy; in December 2011, she was admitted to hospital with a urinary/kidney infection; and in February she commenced treatment for osteopenia. In addition she suffers from dermatitis on her hands and is very overweight, although she has lost some weight. In evidence she told me that she has recently been suffering from vertigo.

6. Mr Zambarda was a great support to his wife. He assisted her in dealing with problems arising from the colostomy bag, which problems have increased over the years. In more recent years he has carried out many of the household chores. In 2002, when he was aged 61 he retired from work due to ill health. Thereafter he devoted his time to caring for her.

7. In recent years he had not had good health quite apart from the mesothelioma. He was diagnosed with diabetes in 2005 but was not insulin dependent; he was overweight; and in 2010 he required bowel surgery for a carcinoma of the caecum. But coronary angiography in 2010 showed only a minor degree of arteriosclerosis and good overall heart function. Investigation in March 2011 showed no evidence of recurrence of his carcinoma.

8. In a witness statement dated 10th June 2011 he stated that he first noticed he was becoming breathless and found difficulty walking in 2010 but the experienced physician Dr Rudd does not attribute these symptoms to the mesothelioma and considers symptoms of mesothelioma first appeared in February 2011. In March 2011 mesothelioma was diagnosed. He died 6 months later in September 2011.

9. It is against this background that damages have to be assessed. The parties have helpfully agreed the following heads of damage inclusive of interest:

Past care and assistance	£ 4,406
Past case management	£ 3,674
Inability to provide services to others	£ 3,656
Miscellaneous expenses	£ 750
Bereavement damages	£11,907
Funeral expenses	£ 3,801
Loss of dependency on Income (past and future)	£70,529
	£98,723

10. The following heads remain for assessment:
<u>Under the *Law Reform (Miscellaneous Provisions) Act 1934*:</u>
General damages for pain, suffering and loss of amenity;
Cost of equipment for the deceased;
Household maintenance, gardening etc;
<u>Under the *Fatal Accidents Act 1976*:</u>
Loss of dependency upon past services;
Loss of dependency upon future services;
Loss of intangible benefits.

The lay evidence

11. I heard oral evidence from Mrs Zambarda, her daughter Mrs Hawkins, and her son Anthony.

12. Mrs Zambarda explained the problems that arose from having a having had a colectomy and having an ileostomy/colostomy bag and the extent to which she had depended on Mr Zambarda for support with regard to these problems. The small amount of bowel available for

the ileostomy/colostomy bag to be attached to, coupled with the parastomal hernia, has meant that leakage at the point where the bag was taped to the skin was a regular problem, especially at night. She said that she would attend herself to a straightforward instance but that Mr Zambarda was always on hand to assist and in the case of a serious leakage, which would necessitate showering and changing the sheets, she was heavily dependent on him: such a need would arise perhaps once a week. She also described blockages, which she said might occur about once a month, and which she described as" terrible", causing excruciating pain. When such occurred Mr Zambarda would help her by walking and supporting her until the pain eased. On occasions he had assisted when she had vomited.

13. Prior to Mr Zambarda's death a case manager had introduced a care regime. When Mr Limb QC for the Defendant suggested that the amount of care had increased after her husband's death she said she thought it had decreased. The position overall since November 2012 is that Allied Healthcare supply a carer between 10am and 2pm who does the housework, prepares Mrs Zambarda's lunch and an evening meal and may take her shopping using the family car. She is then without care save for family visits until 10 am the following morning. On two occasions a carer has stayed overnight: shortly after her husband's death and in March 2012. She said she was very concerned about how she would be able to afford the care she needed.

14. Mrs Zambarda told me that she had now developed a routine whereby, having gone to bed at midnight, she wakes twice nightly to attend to her needs in order to prevent leakages. She has also controlled her diet. As a result she does not frequently have serious leakage problems overnight but should that happen she will use a second bed already made up for her. Two serious leakages overnight would cause serious problems for her.

15. She told me she did not want to rely on her family since they already had many things to worry about. She wants to be independent.

16. I formed a very favourable impression of Mrs Zambarda. She has had to endure far more than most in life but has emerged cheerful. She was a frank and straightforward witness. She is a survivor and said she intended to survive despite the views of the doctors. If longevity were a matter of spirit and courage she would have a very good chance of outliving most of her contemporaries.

17. In her witness statement Mrs Zambarda's daughter, Mrs Hawkins, dealt with care she had given her mother since her father's death. She explained that in December when it was discovered her mother was suffering from E-coli she spent about 13 hours with her. She had attended every hospital appointment with her mother when she had been diagnosed with breast cancer (shortly after her father's death). She set out what she had done during one week in August 2012, which included dealing with paperwork, sorting bills, making telephone calls, visiting her mother to see that she was OK, taking her to church, shopping for her and collecting medicine, preparing meals when a carer did not turn up and taking her out for a break. Work as a carer and looking after her family limited the time she could spend caring.

18. In evidence she said she had now given up work to look after her own family who had their own problems. She lived about 5 miles away from her mother, a 15 minute car drive. She had attended to her mother's stoma only a few occasions since her father's death and had never done so before. There had been one occasion only when she had had to attend her mother because she was bleeding heavily.

19. Mr Anthony Zambarda told me he now lived about 2 miles from his mother. His family too had health problems. On occasions he had had to attend his mother at short notice but generally, it appears, that he did not provide her with "hands on" care.

The expert evidence

20. I received expert medical evidence from Dr Rudd (consultant physician) whose evidence was agreed. Mr George (consultant colorectal and general surgeon instructed by the Claimant), Dr Kroker (consultant geriatrician, instructed by the Claimant) and Dr Phillips (consultant geriatrician instructed by the Defendant) all gave oral evidence. In addition I heard expert care evidence from Ms Wells who had been instructed by the Claimant.

21. Dr Rudd provided two reports on Mr Zambarda, based on a review of his medical records. I have briefly summarised Mr Zambarda's medical history in paragraphs 7 and 8 above and deal with it further below under the heading "Pain, Suffering and Loss of Amenity". Dr Rudd considered Mr Zambarda's coronary angioraphy in 2010 revealed only minor disease of no adverse prognostic significance and noted that thus far Mr Zambarda had remained free of recurrence of his carcinoma. In June 2011 he had estimated Mr Zambarda's life expectancy as 9 months with a significant chance that he may die sooner which, in fact, proved to be the case. He estimated Mr Zambarda's life expectancy as a further 9.6 years had he not died in September 2011.

22. Dr Rudd dealt with Mrs Zambarda's life expectancy in a separate report.

23. Mr George had provided two reports in the form of letters. In his letter dated 2nd August 2012 when dealing with Mrs Zambarda's history, he noted the ileostomy in 1970, further laporotomies for small bowel obstruction, and surgery in 2005 for a para-ileostomy hernia associated with stenosis of the ileostomy. He concluded that she had very little small bowel left, noted that the hernia had since recurred and that Mrs Zambarda had been counselled against further surgery due to the significant risks involved. In oral evidence he put the risk of mortality from further surgery as 30% or more. He said it would take her about 45 minutes in the morning to remove the stoma pouch, clean the area and apply the necessary powders, plaster and tape to provide a seal to prevent leakage. He further said that one of the problems she was running into was increasing leakage due to the pouch lifting off around the parastomal hernia which created the difficult and time consuming problem of further cleaning being necessary. He said it could happen 2 or 3 times per day. He considered she needed care for personal and domestic tasks.

24. In his letter dated 7th February 2013 he said that the greatest risk for Mrs Zambarda was sore skin and subsequent breakdown of the skin around the ileostomy. In evidence he said that bowel contents were acidic and leakage caused soreness. He also said that the parastomal hernia could become acutely obstructed, and if it failed to right itself, that could necessitate emergency surgery. In evidence he made clear that she should avoid putting strain on the hernia by eg by heavy lifting, but acknowledged that a cough could also equally trigger a herniation problem. Should she be operated on successfully then she would need post operative care for perhaps 4, 6 or 12 months.

25. Ms Wells has provided a number of reports. Her first report, dated 6th July 2011, was based on a visit to the Zambarda's home on 22nd June 2011, almost 4 months prior to Mr Zambarda's death. She thought that at that time Mr Zambarda was very low and depressed and recorded that he had not left his home since the end of May. He had ceased caring for Mrs Zambarda, carrying out household tasks and driving. She described Mrs Zambarda as a very determined and strong-minded person and thought that she would try to be independent at night in preference to having night care, which has proved to be the case. She considered immediate care needs could be served by engaging 5 hours domestic assistance per day leaving the family and friends to provide between them some 18.5 hours care/support per week. This would provide care for Mr Zambarda and replace the care he had provided for Mrs Zambarda. She allowed for increased care as Mr Zambarda's condition deteriorated. She considered agency care appropriate but also recommended a case manager as she considered Mr and Mrs Zambarda's situation to be complex and the family all had commitments. She anticipated that following Mr Zambarda's death the case manager would need to establish a care package for Mrs Zambarda.

26. Ms Wells provided a first supplementary report in June 2012. At that time Mrs Zambarda was receiving 6 hours care per weekday and 4 hours care per day at weekends. Ms Wells, whilst not unsympathetic to Mrs Zambarda's needs considered it was extremely difficult to justify the continuation of care at such a high level considering Mrs Zambarda's practical needs, and that it needed to reduce if it was to replace the care that Mr Zambarda had provided. She costed care for the future on the following basis:

Weekly		
Weekday care	22.5	hrs
Weekend care	4	hrs
Escorting on outings	6	hrs
Daughter's (family) care	7	hrs
	39.5	hrs
Monthly		
3 x 3 hours for appointments/shopping	9	hrs
Additional care when immobilised by pain		
Personal care	3	hrs per day
Sleep in care if employed	weekly.	

27. In a second supplementary report dated July 2012 she considered the carers' logs, noted that there had been some excessive care and that the Claimant had received overnight care in March 2012 when she had an exacerbation of back pain. She observed that careful examination of the carers' logs identified the significant value of companionship the carers provided and noted that Mrs Zambarda was now more socially isolated. She identified the importance of psychological support which Mr Zambarda had provided. She also recorded that Mrs Zambarda had recently visited family in Italy, accompanied by her family. In the past Mr and Mrs Zambarda had regularly visited Mr Zambarda's family there.

28. In evidence she maintained that there was a need for family care stating they stepped in when carers failed to turn up. In cross-examination Mr Limb put to her a document which he had compiled which showed that for the period 28th November 2011 - 11th March 2012, after deducting 10 days for the Christmas period, professional care provided had averaged 28 hrs per week; that from 12th March 2012 - 18th November 2012 after deducting 3 weeks, there was an average 30.25 hrs paid care per week; and that from 19th November 2012 - 10th March 2013 after deducting 1 week for Christmas and another week in January the average was 31.5 hrs per week. Ms Wells said that she had recently analysed the invoices and a week's care did not always represent a full 7 days so that Mr Limb's assessment understated the number of hours. Upon scrutiny of her figures it emerged that in round terms Mr Limb's figures underestimated weekly paid care by about 2 hrs per week.

29. Mr Limb took her through her reports pointing out how her assessment of hours required had changed from 29.5hrs to 30 hrs to 32.5 hrs and to 39.5 hours when family care of 7 hrs per week was added. She maintained her opinion that 7 hours per week family care was appropriate.

30. She had trimmed her case management recommendation. In evidence she accepted that the Allied Homecare brochure stated that their charges included case management, queried whether they had in fact provided any but also agreed that if they had not the appointed case manager should have queried that. She considered that at present what the case manager was doing was, essentially, arranging for the care bills to be paid. She thought that Mrs Hawkins was perhaps not the best person to deal with this aspect as she was too committed to her mother's care, which I understood to mean that she might, if left to her own devices, over provide.

31. Although there was a case manager's report in the papers the case manager was not called to give evidence and I ignore the contents of that report save where dealt with by witnesses.

32. I found Ms Wells to be a fair minded witness. It is not often that I have read in a Claimant's care report the opinion that excessive care had been provided or that case manager's charges did not appear justified.

33. Dr Kroker and Dr Phillips both considered what care was necessary to replace Mr Zambarda's care. Dr Kroker took his lead from Ms Wells' assessment of 32.5 hours paid care plus 7 hours family care. Dr Phillips was, as he put it comfortable with 32.5 hours care but less comfortable with 39.5 hours considering that family care would likely have been provided in any event. Ultimately did not seek to disagree with Ms Wells' assessment of 7 hours family care per week.

34. Although not so far apart on the quantity of care provided they differed significantly on what future care would have been provided had Mr Zambarda lived.

35. Dr Kroker's opinion was that Mrs Zambarda's care needs would increase and that Mr Zambarda would have been able to cope with the increased demand until the last year of his life. In a joint statement with Dr Phillips he set out his envisaged scenario which was Mrs Zambarda's care needs increasing from 39.5 hrs per week to 41 hours in 2013-2015, to 42.5 hours in 2015-2017, to 44 hrs in 2017 -2019 and to 45 hours in 2021-2022, all of which extra care Mr Zambarda would have been able to provide save for the last year 2021-2022. His reasoning was that Mr Zambarda had no progressive conditions and in such cases when death came it tended to come relatively quickly. It would therefore be only in perhaps the last 12, perhaps 18 months of his life that Mr Zambarda would have been unable to cope. Dr Kroker had not examined or interviewed Mrs Zambarda.

36. In their joint statement he and Dr Phillips both considered that Mrs Zambarda's condition was likely to deteriorate, in particular due to her lumbar stenosis. In evidence he said that he now thought that she was significantly less mobile than he had earlier considered. The likelihood of complications in her case was high. He instanced the possibility of a fall, a fracture or the need for surgery. It was probable she would need considerable support by 2017-2018 due to a combination of factors. It could be earlier than that. He described the stoma as "a time bomb". He accepted that deterioration could involve a sudden step deterioration affecting her functioning.

37. Dr Phillips, who had examined Mrs Zambarda, said it was a rule of thumb that with people aged say 70 plus, deterioration occurred in the last one third of the remaining life expectancy. That deterioration could be the result of a progressive disease or condition or result from an acute health problem. Thus he took the view that with a life expectancy of 9.6 years, Mr Zambarda would have been unable to cope with Mrs Zambarda's care need for say the last 3 or so years. He had no difficulty in evidence in accepting that he would, at least notionally, be able to cope in the earlier period of the 9.6 years. In the years commencing September 2011 - August 2012 and following he suggested that Mr Zambarda would have continued to be able to provide 32.5 hrs care/support for 2011-2012, 2012-2013, 2013-2014 and 2014-2015 (when Mr Zambarda (DoB 8/1/41) would have been aged 74.66 years old). Thereafter he considered the care Mr Zambarda would have been able to provide would have reduced by 7 hours per week year by year in each of the 3 following years and that in the last 3 years of his life he would not have been able to provide any care.

38. In cross-examination he accepted Mr Steinberg's points that the care/support Mr Zambarda had provided ie stoma care, domestic chores, emotional support etc could, save for physical support, be described as light, although he thought that with time night time support, interfering as it would with sleep, might prove wearing. He would not accept that, given the "light" description of much of the care provided that it was illogical or unreasonable to consider that no care would be provided over the last 3 years.

39. Against this background I turn to the heads of damage that remain to be considered.

40. **Pain, suffering and loss of amenity**
Mesothelioma is a distressing, debilitating and progressive disease. The deceased first experienced attributable symptoms in February 2011 when he was complaining of chest pain. He was soon short of breath on exertion and a chest X-ray showed a large right sided pleural effusion. He underwent a thoracectomy, the effusion was drained and talc was inserted in the hope that it would fill the pleural space and prevent recurrence of the effusion. Removing the effusion would make breathing easier. On 28th March 2011 he was informed of the diagnosis and either then or a little later of the adverse prognosis.

41. Sadly the effusion recurred accompanied by chest pain and breathlessness and a section of the pleura was surgically removed. A pleural drain was inserted in April but removed in May. He then underwent radiotherapy the side effects of which included nausea. His appetite was poor and his mood depressed. He was selflessly but typically concerned about how the Claimant would manage without him.

42. By the end of May he had ceased to leave his home. By July he was lethargic, spending much time in bed. He developed a lump in the right side of his abdomen, was in discomfort and had swelling. He had earlier been prescribed painkillers. Pleural effusion recurred and he was prescribed morphine. He became distressed by his condition, which worsened to the extent that he found it difficult to take oral medication. On 14th September he died surrounded by his loving family.

43. In evidence Mrs Zambarda said that until the last 4 months of his life Mr Zambarda had been able to take her out, that he was able to walk and drive her. The overall picture is of a speedy deterioration in his condition from late May to his death, sadly not an unusual situation with mesothelioma.

44. The Judicial College Guidelines (11th Edition) puts a value of £50,000-£90,000 on mesothelioma suggesting that relevant factors to be borne in mind include duration of the pain and suffering, the effects of invasive investigations, the extent and effects of radical surgery, chemotherapy and radiotherapy, and whether the mesothelioma is pleural or peritoneal, the latter typically being more painful. Whilst acknowledging that most cases of mesothelioma concern those in their fifties, sixties and seventies I would add that I consider age, and the extent of life lost and are also relevant factors.

45. I was referred to the following relatively recently decided cases: *S v Circaprint* [2005] (Master Whittaker) - £67,000 (now £88,500); *Mason-Cave v Massey Plastic Fabrications* [2007] (Master Rose) - £62,500 (now £75,223); *Beesley v Lambie and New Century Group* [2008] (Hamblen J) - £72,000 (now £84,000); *Watson v Cakebread Robey Ltd* [2009] (Satinder Hunjan QC) - £75,000 (now £87,410); *Fleet v Fleet* [2009] (Mackay J) - £77,500 (now £89,270); *Najib v John Laing PLC* [2011] (Nicola Davies J) - £80,000 (now £84,900) as well as some others which seem to me to be of lesser significance. Most of these cases involve longer periods of suffering, in some the suffering was even worse than in the present. The closest to the present would appear to be *Mason-Cave*, where the deceased was in his sixties, received treatment comparable to that received by Mr Zambarda and his period of suffering and expectation of life were close to that of Mr Zambarda.

46. The Claimant contends for £80,000. Mr Steinberg suggested that Mr Zambarda's real concern for Mrs Zambarda was a distinguishing feature which merited a slightly higher award than would otherwise be appropriate.

47. The Defendant contends for £70,000 stating that treatment and symptoms were regrettably typical and that the case lies no higher than in the middle of the bracket.

48. Doing the best I can whilst attempting to keep within the guidelines and in line with other awards I consider £77,500 the appropriate award on the facts of this case.

Past Loss

50. Cost of equipment for the deceased
Of the items claimed, which it is not necessary to list here, the Defendant in his Counterschedule asserts that the claim for mobility scooter and cape, as well as for the second dual rise and recline chair were for the Claimant only. Counsel for the Claimant has accepted that he cannot claim for the second chair but maintains the claim for the scooter on the basis that it was bought for the deceased's use although the Claimant used it later.

51. It appears the scooter was purchased in or soon before August 2011. The case manager's report states it was bought for Mrs Zambarda. Mr Zambarda never used it. Mrs Hawkins told me that Mrs Zambarda already had a scooter but that it was on its last legs but also said it was bought in the hope that her father would benefit from it. She said her mother now rarely used it suggesting she was not safe on it, as could well be the case given her present problems with vertigo.

52. The balance of the evidence suggests it was bought for Mrs Zambarda's use and I am afraid I cannot conclude that if it was bought for Mr Zambarda's use that that was sensible or reasonable at that time. I therefore reject the claim for the scooter. The award under this head will therefore be £3,301.

53. Household maintenance, gardening etc
The claim is for £1,478 +£13 interest. It comprises invoices for £156 and £56 for gardening in August 2011, a further invoice for £99 for gardening in October 2011 and 3 invoices for household maintenance namely:

30th July 2011	Landscape work to garden pond	£500
25th August 2011	Plumbing to boiler and central heating systems	£300
12th September 2011	Erecting fence	£475

The Defendant accepts liability for the gardening invoices (£156 + £56 + £99: total £311). In closing submissions Mr Limb also accepted liability for the garden pond invoice for £500 on the assumption that that was completing work which Mr Zambarda would have done but he did not accept the Invoice for Plumbing (£300) nor for the fencing (£475) on the basis that the deceased would not have carried out these works.

54. The plumbing invoice appears to be for specialist work. The fencing invoice was for 72 feet of fencing, some of it 5 feet high and for fitting concrete posts.

55. In the absence of evidence that these were jobs that Mr Zambarda was competent to do and would have done himself I am not prepared to find such.

56. The award under this head will therefore be £311 + £500: £811 plus the appropriate interest.

Under the *Fatal Accidents Act 1976*

57. Left for decision are:
    (i) Past loss of dependency upon services;
    (ii) Future loss of dependency on services;
    (iii) Loss of intangible benefits.

Life expectancy

58. Before dealing with these heads I shall deal with life expectancy for Mr and Mrs Zambarda.

59. The medical conditions of both Mr and Mrs Zambarda have been taken into account by the medical experts in reaching their conclusions about life expectancy.

Mr Zambarda
Dr Phillips agrees Dr Rudd's assessment of 9.6 years from September 2011, based on an actuarial approach. That would give a life expectancy to 80.3 years.

Mrs Zambarda
Dr Rudd assessed this, actuarially, as 13.6 years as at July 2012. That would now be 12.6 years. Dr Phillips in a report dated 12th November 2012, whilst accepting Dr Rudd's 13.6 years, noting that Mrs Zambarda's state of health had declined more steeply over the last year (ie to November 2012) and would likely steepen further, estimated no more than 12 years from July 2012 which would now be to no more than 11 years. However, Dr Rudd's report has been agreed. I therefore adopt his assessment.

60. Past loss of dependency upon services
The claim is presented on the basis that the services the deceased would have provided have been replaced by paid carers at a cost of £43,705 supplemented with family care of 1 hour per day valued in total at £4,894, adopting hourly rates discounted by 20% for the gratuitous element with care organised by a case manager. In addition there is a claim for loss of dependency on DIY services.

61. The claim for past case management has been agreed. I have dealt with loss of DIY services above.

62. The Defendants by their Counterschedule accept the cost of paid care calculated on the basis of 32.5 hours per week but no more. They allow £50,825.32.

63. It emerged that the Claimant's valuation had erroneously overlooked post March 2013 paid care. In the event the parties agreed £52,000 under this head.

64. The Defendants do not accept the claim for family gratuitous care. As stated elsewhere in this judgment I am satisfied the claim is made out. I am also satisfied given the small sum involved and that one of the reasons for applying the discount is the fact that income tax will not be paid, that a discount of 20% is appropriate. I award £4,894 under this head.

Future loss of dependency upon services

65. The claim under this head is for:
(i) Case management;
(ii) The cost of professional care;
(iii) the value of family care;
(iv) the loss of household services - DIY and gardening.

Case management

66. Strictly speaking Mr Zambarda did not provide case management services for Mrs Zambarda. However, the case is put on the basis that a case manager is now necessary to organise the care necessary for Mrs Zambarda.

67. Case managers are not normally employed in circumstances such as the present. Their employment is more usual where someone, not infrequently due to brain damage, is unable to organise his own care and needs ; and to a lesser extent in serious spinal injuries cases where care packages have to be organised and supervised.

68. Mr Limb points out that Allied Homecare state they provide case management but submits that whereas case management may have been appropriate in the past because of the unusual circumstances which arose, it is no longer appropriate. It was apparent from the evidence that the case manager's role at present is essentially paying bills. I see no reason to employ a case manager for that purpose. I therefore consider continued employment of a case manager is no

longer appropriate. But there is a risk that one may be necessary in the future. I consider an award of £5,000 would cover likely costs.

Professional care

69. I have no doubt that Mr Zambarda provided care/services to his wife going far beyond what a husband would normally provide. Such care was not an option for them. It was a necessity given Mrs Zambarda's disabilities. Apart from relying on Mr Zambarda to provide domestic support, Mrs Zambarda depended on Mr Zambarda for support with regard to the problems she faced due to her ileostomy. The small amount of bowel available for the ileostomy/colostomy bag to be attached to coupled with the parastomal hernia has meant that leakage at the point where the bag was taped to the skin was a regular problem, especially at night. Although she would attend to a straightforward instance herself Mr Zambarda was always on hand to assist and in the case of a serious leakage, which would necessitate showering and changing the sheets, she was heavily dependent on him. Mr George agreed in evidence that both Mr and Mrs Zambarda had had to deal with these problems for so long that they would have been well experienced in what to do. He also used to assist and comfort her when what she described as "a blockage" occurred, which she said might occur about once a month when he would help her by walking her around until it eased.

Duration and Quantification of the loss in hours

70. In her first report Ms Wells assessed weekly care provided as follows:

Hoovering, dusting cleaning	3	hrs
Laundry and ironing	4	hrs
Preparation of meals/washing up	3.5	hrs
Shopping	2	hrs
Domestic chores total	12.5	hrs
Assistance with dressing/providing clothing	3.5	hrs
General fetching and carrying	3.5	hrs
Taking Mrs Zambarda out	4	hrs
Practical care total	11	hrs
Attending to ileostomy problems/blockages and supporting when needed	6	hrs
Total weekly care	32.5	hrs

In addition she concluded that when Mrs Zambarda was suffering from severe back pain the deceased provided an extra 2 hrs care per day.

71. Dr Phillips was comfortable with this assessment of 32.5 hours per week.

72. Ms Wells in her first supplementary report noted services that Mrs Hawkins was now providing and assessed they amounted to 1 hour per day which produced a total of 39.5 hrs pw. Dr Kroker considered this an integral part of the care provided. Dr Phillips considered that the family would have provided this care in any event.

73. Like Dr Phillips I have no difficulty in accepting the basic 32.5 hrs care pw but I also have no difficulty in also accepting that 1 hour's family care can also properly be taken into account.

74. In assessing this aspect of loss of dependency I am of course not concerned to assess what care Mrs Zambarda requires but rather what care Mr Zambarda would have provided. Care can have many aspects. It is not confined to physical assistance but also, in my judgment applies to necessary companionship which Mr Zambarda would have provided, support and comfort, all of which took up some of his time and which is now to an extent supplied by family members especially Mrs Hawkins.

75. When I stand back from the 39.5 hours per week, which represents a little over 5.5 hrs per day I consider this not an overestimate of the care and support Mr Zambarda provided.

76. Duration of the loss is a difficult area where Drs Kroker and Phillips are significantly apart. The evidence is clear that Mrs Zambarda's very significant health problems put her at serious risk of requiring more care, and quite possibly significantly more care, as she ages. She is particularly at risk from advancement of her lumbar stenosis causing likely further adverse problems with mobility whilst her ileostomy, parastomal hernia and skin breakdown also give rise to risks of a serious deterioration in her condition. The problem is that no-one can know with any certainty whether and if so when what problems will manifest themselves.

77. At the same time Mr Zambarda's health, had he lived, may well have affected his continuing ability to care. Dr Kroker was optimistic about this but I am not so sure. Whilst Mr Zambarda had no obvious progressive condition one can never know how health may change in later life. Happily his cancer had not reasserted itself but he must have been at risk to that happening.

78. With such uncertainties I prefer Dr Phillips' rule of thumb approach but with reservations. My reservations derive from the fact that the care provided was essentially light in nature and something which Mr Zambarda would have been likely for the most part to continue to provide subject to some serious set back in his health. Should Mrs Zambarda's mobility have declined then she may well have required physical care Mr Zambarda could not have provided but nevertheless he would have been able to continue to provide less demanding care.

79. Dr Phillips limited Mr Zambarda's ability to provide 32.5 hrs weekly care to 2014-2015. I consider that Mr Zambarda would likely have been able to continue beyond that or to put it another way, that there was a very good chance that he would have been able to.

80. Doing the best I can, faced with the uncertainties, I consider Mr Zambarda would have been able to continue with the comparatively light care he was providing to Mrs Zambarda, which I assess as a basic 39.5 hours per week, until January 2017 when he would attain his 76th birthday. Then I consider his ability to provide would decrease by 7 hours per week in each of the 3 following years (ie first year 7 years, second year 14 years and third year 21 years) until January 2021, when he would be aged 79, when his ability to care would for practical purposes cease.

81. Of these hours care I consider 7 hours will be replaced by family care until January 2017. The decreasing 7 hours per annum will then need to be replaced by professional care. Thereafter ie from January 2021 on, such care as Mrs Zambarda will need would have had to be provided either by visiting carers or family in any event.

82. I consider that such provision would replace the basic care that Mr Zambarda would have provided. In addition there would have been periods when Mrs Zambarda's care demands beyond the basic requirement would have been met by Mr Zambarda, but which it is not reasonable to expect to be provided now by the family. In the last year Mrs Zambarda's health appears not to have imposed significant extra demands for care but the future may well be different. I assess such future further care to average at about 2 hours per week until January 2021 which need will in future have to be met by professional care.

83. There is no dispute about the hourly rates claimed.

84. I would be grateful if counsel would calculate the cost of such care in the light of my findings.

Family care

85. It will be apparent from the above that I consider it appropriate to continue to allow for family care at the rate of 7 hours per week. Valuation of this head should be based on the fact that family care replacing Mr Zambarda's care will also cease in January 2021.

Loss of household services – DIY, gardening

86. The sum claimed, £830 pa, is suggested by the Claimant's counsel to be modest and in my experience is modest subject only to Mr Zambarda's continuing ability to provide such services. The claim is based on an assessment by Ms Wells who also says she lacks experience in making such valuations. But a full multiplier of 6.35 is claimed producing £5,270.

87. For the Defendants Mr Limb offers £1,250 pa from the date of death to age 75, a total of £5,116.25.

88. I would also allow £1,250 pa but to age 77. I would be grateful if counsel would kindly calculate the loss.

Loss of intangible benefits

89. This is now a recognised head of loss but it is also recognised that awards should be modest. In the present case I am quite satisfied that Mr Zambarda provided far more intangible benefits than the conventional husband largely because Mrs Zambarda needed those benefits for her well being. I consider £4,000 an appropriate award.

Final award

90. The claim therefore has the following value:

Item	Amount
Under the Law Reform Act	
Pain suffering and loss of amenity	£ 77,500
Interest thereon	£ 1,550
Past care and assistance + interest (agreed)	£ 4,406
Past case management + interest (agreed)	£ 3,674
Equipment	£ 3,301
Interest thereon*	
Inability to provide services to others + interest (agreed)	£ 3,656
Household maintenance	£ 811
Interest thereon*	
Miscellaneous expenses + interest (agreed)	£ 750
	£ 95,648
Under the Fatal Accidents Act	
Bereavement + interest (agreed)	£ 11,907
Funeral expenses + interest (agreed)	£ 3,801
Income dependency (past and future)	£ 70,529
Past dependency on services	£ 71,694
Future dependency on services*	
Loss of intangible benefits	£ 4,000
	£161,931

91. The items with an asterisk need to be quantified. When counsel have agreed those calculations I shall hand down this judgment in final form.

Addendum

92. The parties have now agreed the items with an asterisk as follows:

(i)	Interest on Past Equipment	£30.00
(ii)	Interest on Past Household maintenance	£7.38
(iii)	Future dependency on services (including £5,000 for case management)	£171,065

93. They have also agreed that credit of £620.48 should be given for interest on interim payments totalling £110,000 (which I have subtracted from the Fatal Accidents Act claim) and certificated Compensation Recovery Unit payments of £1,764.20.

94. There will therefore be judgment for £428,061 to the nearest pound apportioned as follows:
    i) £ 95,685 under the Law Reform (Miscellaneous Provisions) Act 1934: and
    (ii) £332,376 under the Fatal Accidents Act 1976.

95. After credit is given for the interim payments totalling £110,000 and benefits of £1,764.20 there remains a balance due of £316,296.80 which is to be paid to the Claimant's solicitors by 4pm on 31st July 2013.

96. In addition there will be an order that the Defendant pays the Claimant's costs on a standard basis to be the subject of a detailed assessment if not agreed, those costs to include the costs of calling Mr George to give evidence. There will also be an order that the Defendant makes an interim payment of £75,000 on account of costs, this sum to be paid by 4pm on 31st July 2013.

I direct that pursuant to CPR PD 39 Para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.