QB-2018-000300

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

[2019] EWHC 1512 (QB)

Royal Courts of Justice
Strand, London, WC2A 2LL

18 June 2019

Before :

MASTER DAVISON

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Between :

CAROL DODDS **(A protected party by her sister and litigation friend JANICE DODDS)**	**Claimant**
- and - **MOHAMMAD ARIF (1)** **AVIVA INSURANCE LIMITED (2)**	**Defendants**

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Mr Robert Hunter (instructed by **Leigh Day**) for the **Claimant**
Mr Patrick Vincent (instructed by **DWF**) for the **Defendants**

Hearing date: 4 June 2019

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Approved Judgment

I direct that pursuant to CPR PD 39A 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.

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Introduction

1. At the case management conference on 4 June 2019 I refused the defendants permission to rely upon the expert evidence of Professor Bowen Jones as to the claimant's life expectancy. Due to pressure of time and due also to the fact that the decision to refuse permission for "bespoke" life expectancy evidence had some possible bearing on other cases, I said I would give my reasons in writing at a later stage. This I now do.

2. The claimant, Carol Dodds, was born on 15 August 1943 and is currently aged 75. On 6 February 2017, when she was 73, she was struck by a car driven by the first defendant whilst she was crossing a road in south west London. The main injury was a traumatic brain injury, classified as moderate or severe. There was a 12 week period of post-traumatic amnesia (which is an indicator of neuropsychological outcome). She is a protected party. Her litigation friend is her sister, Janice. They live in a flat. Her sister is her main carer. She is able to perform most of the activities of daily living. But she has a substantial cognitive impairment and she requires a good deal of support.

The medical evidence

3. The claimant has disclosed expert reports from Dr Sylvester, a neurologist, and Dr da Costa, a geriatrician. Dr Sylvester's report is dated 19 July 2018. That of Dr Da Costa is dated 21 February 2019.

4. Dr da Costa comments on the claimant's general health prior to the accident, the effects of the accident on the ageing process and the impact of the accident on the claimant's daily activities. (The report addresses a number of points made by the defendants in correspondence concerning the impact of the claimant's previous medical history on her level of function.)

5. Dr Sylvester's report is primarily directed to the neurological consequences of the accident. These have included the claimant's cognitive impairments, issues with balance and fatigue, reduced sense of smell and reduced visual field and psychological symptoms. The report also deals (but only very briefly) with life expectancy. Dr Sylvester's view is unless the claimant develops epilepsy (as to which there is a 5% risk) her life expectancy "is unlikely to be significantly reduced".

6. The defendants have disclosed a report from Professor Bowen Jones, a distinguished consultant physician who has published a number of papers on mortality and life expectancy. This is his special field of interest and the only area he was invited to comment upon in relation to this claimant. His report is dated 10 September 2018. He has used what is commonly referred to as the "Brackenbridge" methodology. He refers to this as the standard method where multiple risk factors interact. Its fuller name is "The Rating of Substandard Lives". Applying this approach, and using a baseline mortality rate which is based upon the same life tables as used in the Ogden Tables, he expresses the opinion that the claimant's pre-accident life expectancy had to be adjusted downwards for her high blood pressure and raised cholesterol and upwards for her non-smoking status – the net result being an overall reduction of 3.29 years from her "Ogden prediction" of 16.89 years. Post-accident, his opinion is that the effect of head injury has further reduced the claimant's life expectancy so that it now stands at 15.08 years – a total reduction of 5.08 years.

The arguments advanced at the Case Management Conference

7. The claimant resisted the defendants being given permission to rely upon the report of Professor Bowen Jones. Mr Hunter submitted that the orthodox position was that it was the clinical experts who were the normal and primary route through which the issue of life expectancy was to be addressed. This did not exclude consideration of statistical evidence. But such evidence was, at least in the first instance, still the province of the clinical experts; see Arden v Malcom [2007] EWCA 404 and The Royal Victoria Infirmary v B (A Child) [2002] EWCA Civ 348 CA at paragraph 39. Life expectancy evidence as such was only appropriate in a case

where the claimant was "atypical"; (see below). This claimant's pre-existing medical conditions did not make her atypical and there was therefore no basis to give permission in this case. Mr Hunter submitted that if I gave permission in this case, I would be giving it in very many cases and that would be quite contrary to the principle that, in personal injury claims, life expectancy was catered for by applying the Ogden Tables and not by "bespoke" life expectancy evidence.

8. Mr Patrick Vincent, for the defendants, countered these submissions with the proposition that the claimant was indeed "atypical" because she had a head injury which had reduced her life expectancy. That being so, evidence directed to this issue was required. There was no firm rule that such evidence had to come from a clinical expert, (which in this case would be a neurologist). Not all clinical experts were in a position to express an opinion on life expectancy. Some would. Others would not. If, as here, what was needed was an opinion on life expectancy, why should not a party be permitted to go to an expert in that very field?

Discussion

9. I refused the defendants permission to rely upon the report of Professor Bowen Jones, but for reasons that were not fully aligned with Mr Hunter's submissions.

10. Life expectancy is an important issue in the field of personal injury litigation. But in the ordinary run of cases, there is no medical evidence on it. This is because life expectancy and the multipliers derived from life expectancy are taken from the Ogden Tables. The Explanatory Notes to the Tables state as follows:

> "4. The tables are based on a reasonable estimate of the future mortality likely to be experienced by average members of the population alive today and are based on projected mortality rates for the United Kingdom as a whole …
>
> 5. The tables do not assume that the claimant dies after a period equating to the expectation of life, but take account of the possibilities that the claimant will live for different periods, e.g. die soon or live to be very old. The mortality assumptions relate to the general population of the United Kingdom. However, unless there is clear evidence in an individual case to support the view that the individual is atypical and will enjoy longer or shorter expectation of life, no further increase or reduction is required for mortality alone."

11. The cohort used for the Ogden Tables is a general cohort which includes lives affected by a variety of medical conditions, lifestyles (including smoking) and localities. The Tables are designed to achieve broad justice for personal injury cases generally. Bespoke evidence on life expectancy is not generally permitted unless the condition set out in paragraph 5 of the Explanatory Notes is met. There must be "clear evidence to support the view that the claimant is atypical". This proposition is clearly illustrated by the case of Edwards v Martin [2010] EWHC 570. The claimant suffered a head injury which the neurologists agreed had no effect on life expectancy. However, the claimant was a smoker and had some history of depressive illness. Clarke J refused to depart from the conventional, Ogden Tables multiplier. His reason was that the medical evidence did not take the claimant into the category of someone who, within the words of the Explanatory Notes, was "atypical and will enjoy a longer or shorter expectation of life"; see paragraphs 69 – 72 of the judgment. That reasoning remains entirely valid and it is worth mentioning that it applies equally to claimants as it does to defendants. Thus, it is apparent that Clarke J would not have departed from the Ogden Tables multiplier on the grounds that, for example, the claimant was a fit non-smoker with no particular health problems.

12. This case, however, is different from Edwards v Martin. On any view of the evidence, the claimant's head injury has had some / some potential impact on her life expectancy. Dr Sylvester has said in terms that, unless the claimant develops epilepsy, her life expectancy is unlikely to be "significantly affected", which implies at least some effect. If she develops epilepsy, the effect on life expectancy will be significant. It is clear that Dr Sylvester's opinion needs to be expanded and clarified and the normal route for doing that would be a supplementary report and/or Part 35 questions to him.

13. The defendants did not go down this route but chose, rather, to instruct Professor Bowen Jones – something they did without first canvassing the instruction with the claimant, (as to which, see further below).

14. The issues presented by this instruction were: (i) whether life expectancy evidence was required at all, and (ii) if so, whether "bespoke" life expectancy evidence from an expert in that particular field was required, or whether the evidence should come from the clinical experts. In each case, phrased in terms of CPR rule 35.1, "required" means "reasonably required to resolve the proceedings". And this rule, as with all rules of procedure, needs to be construed in the light of the Overriding Objective.

15. As I have already indicated in paragraph 12 above, the answer to the first question is, Yes. Life expectancy evidence is required in this case. It is not required because the claimant is "atypical" within the meaning of the Explanatory Notes to the Ogden Tables. That expression is directed towards outliers from the population cohort comprised in the Tables who, because of special factors relating to their general health, could be expected to enjoy longer or shorter life expectation. The reason it is required in this case is simply that the injury has reduced the claimant's life expectancy and the court will have to decide by how much in order to arrive at the correct multipliers. That can only be done with the aid of expert medical evidence.

16. The answer to the second question is, No. "Bespoke" life expectancy evidence from an expert in that particular field is not, or certainly not yet, required. There are several reasons for this, which are grounded both in principle and practicality.

17. First, life expectancy is and has often been held to be "a medical, or clinical, issue"; see for example the judgment of Sir Anthony Evans in the Royal Victoria Infirmary case at paragraph 39. This means that the statistical evidence which forms the basis of an opinion from a life expectancy expert such as Professor Bowen Jones is regarded as only a "useful starting point" on the way to an "inter-disciplinary approach"; see the judgment of Tuckey LJ at paragraph 20; see also the judgments of HHJ Macduff QC in Lewis v Royal Shrewsbury Hospital NHS Trust [2007] 1 WLUK 628 and that of Lloyd-Jones J in Sarwar v Ali [2007] EWHC 274. In the latter case, Lloyd Jones J stated that the use of statistics was "no more than a starting point. The court is not engaged in a mechanical exercise and what matters is the clinical judgment of the experts on the facts of this particular case". Thus, the issue of life expectancy is normally channelled towards the clinical experts. In the Arden v Malcom case (see above), Tugendhat J said this, at paragraph 36:

> "In my judgment it is in the spirit of the decision of the Court of Appeal in the Royal Victoria Infirmary case that the clinician experts should be the normal and primary route through which such statistical evidence should be put before the court. It is only if there is disagreement between them on a statistical matter that the evidence of a statistician, such as Professor Strauss, ought normally to be required."

18. Second, in practical terms it is usually very much more convenient and cost-effective to ask the clinical experts for their opinion on life expectancy. They will already be instructed and can deal with life expectancy together with the other matters they are concerned with (in this case the claimant's cognition and other neurological problems). It is commonplace for clinical experts to express their opinion as to life expectancy by reference to a reduction from the Ogden Tables average – sometimes called a "top-down" approach. This is a clear and accessible method which, if adopted, makes the choice of a suitable multiplier a simple matter. It is certainly not in every case that recourse (or further recourse) to statistics is required. But if it is, then such material is still, in the first instance, a matter for the clinicians and it is only in the case where they disagree on how to apply the statistics that an expert such as Professor Bowen Jones might be required. A further factor pointing in favour of the clinical experts and against bespoke life expectancy experts is that the latter are in very short supply. If it became a frequent practice to instruct them, then that would have the effect of introducing delay as well as considerable extra cost – to no great advantage.

19. For these reasons, it seems to me that bespoke life expectancy evidence from an expert in that field should be confined to cases where the relevant clinical experts cannot offer an opinion at

all or state that they require specific input from a life expectancy expert (see e.g. Mays v Drive Force (UK) Limited [2019] EWHC 5), or where they deploy, or wish to deploy statistical material, but disagree on the correct approach to it. This case does not, or does not yet, fall into any of these categories.

20. It remains to deal with two specific points arising out of counsel's submissions.

21. In the course of his submissions Mr Vincent pointed out that Professor Bowen Jones, whilst not a neurologist, is, nevertheless, a clinician. He was not offering mere statistics. He was offering an opinion on life expectancy which, whilst based on statistical methodology, was nevertheless tailored to the claimant's case and her particular health profile. My view is that this submission does not meet the general objection to using a life expectancy expert as a "first port of call". Professor Bowen Jones describes himself at page 3 of his report as a specialist in endocrinology and diabetes. These do not feature in this claimant's presentation. His report is a desktop report and at page 10 he acknowledges that the method used is an actuarial method. It is apparent from his lengthy discussion of the various factors bearing on the claimant's life expectancy (including her head injury) that his approach to these factors is primarily actuarial or statistical. I do not accept that his report can fairly be characterised as a report from a clinician, as that term has been used in the cases I have referred to. Further, to the extent that it could be so described, he is the wrong clinician. His specialism is as stated above when the appropriate clinician in this case would be a neurologist.

22. Mr Hunter, for his part, criticised Professor Bowen Jones' report on the ground that he had not explained how the conditions of elevated cholesterol and raised blood pressure made the claimant "atypical" and took her out of the Ogden Tables cohort. Mr Hunter pointed out that these conditions were common. The short answer to this criticism is the one already given, namely that it was not incumbent on Professor Bowen Jones or the defendants to show that the claimant was "atypical" as that expression is used in the Explanatory Notes. She has a head injury which impacts or potentially impacts on life expectancy and that suffices to justify evidence on that matter. However, Mr Hunter's criticism raises a wider point, which is whether an expert considering life expectancy is bound to take the Ogden Tables as a starting point. I do not think that the expert is subject to any such constraint. If there is to be life expectancy evidence – from whatever source – it is not for the court to dictate how the medical expert goes about it. To put it another way, if the index injury has reduced life expectancy such that an expert must offer an opinion as to by how much, that expert has a "clean sheet". (S)he may use a "top down" approach, which starts with the Ogden Tables and discounts as appropriate or a "bottom up" approach which starts with the impact of the injury. These are matters for the expert, albeit that the court will have to evaluate the evidence and arrive at a finding.

Summary

23. To summarise, the authorities on this topic seem to me to support the following propositions:

    i) Where the claimant's injury has not itself impacted upon life expectancy, permission for this category of evidence will not be given unless the condition in paragraph 5 of the Explanatory Notes is satisfied, namely that there is "clear evidence … to support the view that the individual is atypical and will enjoy longer or shorter expectation of life".

    ii) Where the injury has impacted on life expectancy, or where the condition in paragraph 5 of the Explanatory Notes is satisfied, the "normal or primary route" for life expectancy evidence is the clinical experts.

    iii) The methodology which the experts adopt to assess the claimant's life expectancy is a matter for them.

    iv) Permission for "bespoke" life expectancy evidence from an expert in that field will not ordinarily be given unless the clinical experts cannot offer an opinion at all, or for reason state that they require specific input from a life expectancy expert, or where they deploy, or wish to deploy statistical material, but disagree on the correct approach to it.

Dr da Costa and the parties' approach to instructing experts

24. There are two postscripts, the first concerning Dr da Costa and the second concerning the approach adopted by the parties to instructing experts.

25. I gave permission for Dr da Costa's evidence because it addressed a number of matters that had been clearly put in issue by the defendants in correspondence and which were very relevant to the quantification of the claimant's claim. These included the extent to which the claimant's requirement for care had been accelerated by the accident and the effect on her of her co-morbidities. Having put these matters in issue, it was, perhaps, an unattractive stance on the part of the defendants to oppose permission.

26. That said, in the case of both Dr da Costa and even more pertinently Professor Bowen Jones, the parties would have been wise to canvass their instruction with each other. The rules do not make this mandatory, though both the Pre-Action Protocol and the form of the Directions Questionnaires to be filed under CPR Part 26 encourage it. In the case of an expert whose instruction may be controversial, a discussion is good practice. In the case of Professor Bowen Jones, this would have allowed the claimant's advisers to set out for the benefit of the defendants their reasons for resisting his instruction. Those reasons were well-founded and have prevailed. The cost of instructing the Professor has been wasted. That was avoidable.