OUT OF THE ORDINARY

Rob Hunter and Bethany Sanders on the courts' approach to life expectancy evidence

When and why have Courts given permission for expert evidence on life expectancy? In *Dodds v Arif & Anor* [2019] EWHC 1512 (QB), Master Davison dismissed the defendants' application to rely on a bespoke report concerning the claimant's life expectancy and provided a helpful overview of the principles he had applied.

Background

Life expectancy is fundamental to the calculation of damages for personal injury.

In moderate to higher value cases – where lump sum settlements remain the norm – the life multiplier will be applied to most heads of claim. In catastrophic injury claims, even assuming periodical payments for certain heads of loss, other continuing losses are normally capitalised.

Now that the discount rate has stabilised at -0.25%, some claimants may prefer to capitalise more of their losses. Others may feel obliged to take a lump sum if there is a shortfall on liability. So, almost invariably, large-loss claims will require an assessment of life expectancy.

The starting point for the assessment is the presumption that life expectancy is normal (*Rowley v London and North Western Railway* (1873) LR 8 Ex 221)).

More than a century after *Rowley*, section 10 of the Civil Evidence Act 1995 provided for the admissibility of the *Actuarial Tables with explanatory notes for use in Personal Injury and Fatal Accident Cases*, affectionately known as the Ogden Tables. In practice, 'normal' multipliers are usually taken from Tables 1 to 26 as these are based on average life expectancy statistics collated by the Office of National Statistics, albeit not the latest data.

The explanatory notes summarise the approach taken to life expectancy:

> '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...
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> '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, eg. 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.'

Whether an individual is 'atypical' is simply the other side of the coin of the presumption of normality.

The policy underpinning the Ogden Tables is that the application of population averages does justice in the broad spectrum of claims, and avoids the need for individual estimates. This has obvious advantages in saving costs and promoting settlement through certainty.

The focus of this article is the question of when it is appropriate to depart from the assumption of normality and the Ogden Tables multipliers. In particular, when is it necessary to show that the claimant is 'atypical', and what does this mean?

Who is normal?

In catastrophic claims, it is generally appropriate to depart from normal life expectancy because of the impact of the injury.

Typically, the question is where the claimant falls within a cohort of those with a similar condition (be it cerebral palsy, other brain injury or spinal injury). This is a 'bottom-up' exercise informed by the claimant's particular characteristics and the medical literature concerning the condition in question (be it Brooks / Strauss, Brooks / Shavelle or Frankel / De Vivo, respectively). Analysis of the literature is beyond the scope of this article.

The question of when it is appropriate to depart from the Ogden Tables is more problematic in serious injury – as distinguished from catastrophic – claims. Similar issues also arise in fatal accident claims.

Classically, defendant's representatives have sought to introduce expert evidence to the effect that extraneous medical conditions or lifestyle choices have reduced the claimant's life expectancy to less than the norm. Alternatively, the injuries themselves may have had some impact on life expectancy.

Two reported cases in 2019 illustrate how Courts have come to different conclusions on the evidence required to resolve this issue.

Mays v Drive Force (UK) Ltd [2019] EWHC 5 (QB)

In *Mays*, Deputy Master Hill QC decided to admit expert evidence on the issue of the claimant's life expectancy in addition to reports from the clinical experts.

The claimant had been involved in a fall at work resulting in a traumatic brain injury and orthopaedic injuries. He was a smoker, obese and had suffered from hypertension and ulcerative colitis prior to the accident.

The defendant submitted that the claimant had co-morbid conditions in addition to the injury that affected his life expectancy. There were a range of factors of potential relevance and the neurologists were not able to address them.

The defendant had instructed Professor Bowen-Jones, a Consultant Physician and Endocrinologist, who concluded that the global impact would be a reduction of approximately 11 years.

The claimant argued, among other things, that separate statistical evidence was normally reserved for cases in which the clinical experts had interpreted the data in a fundamentally different way. It was suggested that if Professor Bowen-Jones' evidence was admitted, it would lead to him or a similar expert being instructed frequently. Certain aspects of Professor Bowen-Jones' evidence were also criticised.

Deputy Master Hill QC was not persuaded by what he described as the 'floodgates' argument. In his judgment, the trial judge would decide whether statistical evidence was of assistance, and would consider any challenges that were made to the credibility of the evidence.

Permission for life expectancy experts was granted to both parties.

The obvious disadvantage of the approach taken in *Mays* is that it generated considerable cost without deciding whether the evidence would in fact assist the trial judge.

Although referenced in the judgment, it is questionable whether Deputy Master Hill QC had given sufficient weight to the policy considerations against admission.

Nonetheless, it is easy to sympathise with the judgment in circumstances where the clinical experts (neurologists) had advised that they were unable to comment on the effect of the pre-morbid conditions. One of the conditions, colitis, was arguably not an 'everyday' condition.

It hardly needs to be said that the Court did not decide that the evidence of Professor Bowen-Jones would *in fact* assist the trial judge at trial, or that standalone life expectancy experts would ordinarily be appropriate.

Dodds v Arif & Anor [2019] EWHC 1512 (QB)

The issue arose again before Master Davison in *Dodds*, in which the claimant resisted the defendants' application for permission to rely on Professor Bowen-Jones, whose evidence had been permitted in *Mays* only a few months earlier.

Ms Dodds was injured at the age of 73 when she was struck by the first defendant's car.

Her main injury was a moderate to severe traumatic brain injury (TBI), which had lasting consequences. Pre-morbidly, she had elevated cholesterol and raised blood pressure.

A neurologist instructed by the claimant had addressed life expectancy. His view was that unless the claimant were to develop epilepsy (as to which there was a 5% risk), her life expectancy was 'unlikely to be significantly reduced'.

The defendants disclosed a report from Professor Bowen-Jones. He had applied the Brackenridge Rating of Substandard Lives methodology, and concluded that the claimant's pre-accident life expectancy fell to be reduced for high blood pressure and raised cholesterol, but increased for non-smoking status, with a net reduction of 3.29 years.

In his opinion, the head injury further reduced the claimant's life expectancy so that there was an overall reduction of 5.08 years against the baseline mortality drawn from Ogden Table 1.

The defendants averred that the claimant was 'atypical' because she had a head injury which had reduced her life expectancy. That being so, evidence on life expectancy was required and there was no firm rule that such evidence had to come from a clinical expert.

The claimant argued the orthodox position was that the evidence of clinical experts provided the normal and primary route through which the issue of life expectancy was to be addressed, citing *Arden v Malcom* [2007] EWCA 404 and *The Royal Victoria Infirmary v B (A Child)* [2002] EWCA Civ 348 CA.

It was also argued that the Ogden Tables do justice because they are based on the general population, which includes those with various medical conditions and lifestyles, and so life expectancy evidence was only appropriate in a case where the claimant was 'atypical' (*Edwards v Martin* [2010] EWHC 570).

Master Davison accepted the claimant's first argument but rejected the second. He concluded that expert evidence was reasonably required because the injury had reduced the claimant's life expectancy, but that it should come from the clinical experts.

In his judgment, bespoke life expectancy evidence should be confined to cases where the clinical experts required assistance (such as *Mays*), or where there was a disagreement in relation to the actuarial statistics.

This was partly for pragmatic reasons, as the instruction of bespoke life expectancy experts was likely to result in delay and considerable cost, but also right as a matter of principle.

Master Davison drew the following propositions from the authorities (see paragraph 23):

i. Where the claimant's injury had not itself impacted on life expectancy, permission for standalone evidence on life expectancy 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 some 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.

Comment

Master Davison's approach has much to commend it. However, the suggestion that a reduction in life expectancy as a result of the injury is a gateway to expert evidence is problematic.

In catastrophic injury claims, this is likely to be the position, because the claimant's life expectancy will be substantially affected by the injuries, and this has been implicit in many of the reported cases. But in serious injury claims, the position is different.

In moderate to higher value claims, the impact of the injury may or not be enough to displace the presumption of normality.

In Ms Dodd's claim, there was a small risk of epilepsy as a result of the accident and certain other conditions. Some in the general population will develop epilepsy – whether or not as a result of a defendant's negligence – and very many will have high blood pressure and / or cholesterol, particularly those in their seventies.

The essential background is that the prediction of life expectancy is fallible. The Ogden Tables are based on UK-wide statistics that encompass all income groups and localities, the fit, the obese, smokers and non-smokers, and so forth. The only reliable assumption is that every claimant will live for longer or shorter than predicted.

In this context, it is submitted that the question for the Court is always whether it is appropriate to admit evidence in favour of departing from the broad averages, not simply because the injury has had some effect, but because the claimant is so unusual ('atypical') that justice demands it.

There is a danger of whittling down the population averages on account of conditions that are already part of the cohort. This is a misguided search for greater accuracy than can be achieved.

Conclusion

In summary:

i. The question of when it is appropriate to depart from the Ogden Tables is a particular source of contention in serious injury claims. It also arises in fatal accident claims.

ii. There are sound policy reasons why the Courts are reluctant to admit expert evidence for the purpose of reducing, or augmenting, the statistically normal mortality figures.

iii. Where the claimant's injury has not impacted on life expectancy, clear evidence that the claimant is atypical is required to displace the Ogden Tables.

iv. If the injury has impacted on life expectancy, *Dodds* is authority for the proposition that expert evidence will be admissible, although this is open to question.

v. Even if expert evidence is admissible, permission for 'bespoke' life expectancy evidence will not ordinarily be given unless the clinical experts cannot provide satisfactory evidence on the issue.

Practice points for claimant lawyers are as follows:

i. Attempts by defendants' representatives to introduce evidence that a claimant's life expectancy is reduced may be resisted on the grounds that the claimant is not 'atypical', particularly if negative lifestyle factors are relied on.

ii. If life expectancy is in issue, in the first instance it will be for one or more of the clinical experts to address it.

iii. If the injury has reduced life expectancy and this functions as a gateway to expert evidence, claimants' representatives should consider whether positive factors such as non-smoking status, healthy weight, and so forth outweigh any reduction.

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