Neutral Citation Number: [2026] EWHC 2825 (KB)

Case No: KB-2023-MAN-000307

IN THE HIGH COURT OF JUSTICE
KINGS BENCH DIVISION
MANCHESTER DISTRICT REGISTRY

The Civil Justice Centre
1 Bridge Street West, Manchester, M60 9DJ

Date: 2 November 2026

Before :

HHJ Malek
(Sitting as a judge of the High Court)

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Between :

CRE (A Protected Party by her Litigation Friend MHL) **Claimant**

- and -

SNY **Defendant**

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- -

Mr Michael Lemmy (instructed by **Simpson Solicitors**) for the **Claimant Mr James Arney KC** (instructed by **HF Limited**) for the **Defendant**

Hearing date: 7 October 2026

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JUDGMENT

I direct that pursuant to CPR PD39A 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.

HHJ Malek :

Introduction

1. This is the Defendant's application for permission to rely upon expert evidence from Dr Brooks, a consultant specialising in life expectancy evidence.

2. The application arises in the context of a substantial personal injury claim brought by the Claimant, who suffered a traumatic brain injury in the accident which took place on 6 September 2020, giving rise to these proceedings. Liability has been admitted, but quantum remains in issue. One issue relevant to quantum concerns the Claimant's life expectancy and, in particular, whether it has been reduced by reason of the injuries sustained in the accident and associated sequelae.

3. A trial on the issue of quantum and causation is listed for 10 days commencing on 2 November 2026. The parties have complied with directions and already obtained expert evidence in a number of disciplines, including neurology, neuropsychiatry and rehabilitation medicine. Joint discussions have taken place and joint statements have been prepared.

4. The Defendant contends that further expert evidence is now reasonably required in the form of a bespoke life expectancy report from Dr Brooks. The Claimant opposes the application.

5. The application therefore raises the increasingly familiar question considered in a number of recent authorities: in what circumstances should the court permit expert evidence from a specialist life expectancy expert rather than leaving life expectancy to be addressed through the relevant clinical experts.

The Applicable Legal Principles

CPR 35

6. The starting point is CPR 35.1, which provides that expert evidence is to be restricted to that which is reasonably required to resolve the proceedings. The rule reflects the well-established principle that expert evidence is an exception to the ordinary process of fact-finding. The court is not concerned merely with whether proposed evidence may be relevant, admissible or potentially of assistance. Many forms of evidence satisfy those descriptions. The statutory test is whether the proposed evidence is reasonably required for the fair determination of the issues arising in the particular case.

7. The application of that test necessarily calls for an evaluative judgment. The court must consider the issues which genuinely arise for determination, the evidence already available to it, the extent to which the proposed evidence fills an identified

evidential gap, and the consequences of permitting further expert evidence at the stage which the litigation has reached.

8. In the present case the parties referred me to four authorities dealing, directly or indirectly, with questions of life expectancy evidence: *Royal Victoria Infirmary & Associated Hospitals NHS Trust v B (Child) [2002] EWCA Civ 348*, ("*Royal Victoria*"), *Stephen Mays (a protected party by his litigation friend the Official Solicitor) v Drive Force (UK) Ltd [2019] EWHC 5 9QB)* ("*Mays*"), *Carol Dodds (a protected party by her sister and litigation friend Janice Dodds) v (1) Mohammed Arif (2) Aviva Insurance Ltd [2019] EWHC 1512 (QB)*, ("*Dodds v Arif*") and *Toby Chaplin (by his mother and litigation friend Diane Chaplin) v (1) Ben Pistol (2) Allianz Insurance PLC [2020] EWHC 1543 QB* ("*Chaplin v Pistol*"). It is convenient to address each in turn.

Royal Victoria

9. The starting point is the decision of the Court of Appeal in *Royal Victoria*, which is the only binding authority to which I was referred.

10. The case concerned the assessment of life expectancy in the context of serious injury litigation. In the course of its reasoning, the Court recognised that the determination of life

expectancy may properly be informed by statistical and epidemiological evidence as well as by conventional clinical opinion. The Court contemplated an interdisciplinary approach in which medical evidence and statistical material are considered together in assessing future longevity.

11. Mr Arney relies upon the decision as demonstrating the importance of ensuring that the court is equipped with the best available evidence when determining issues of life expectancy. I accept that submission. The authority plainly recognises that statistical and epidemiological material may provide valuable assistance and that courts should seek, as far as reasonably practicable, to determine life expectancy upon a sound evidential footing.

12. However, it is equally important to recognise the limits of the decision. The Court of Appeal was not concerned with an application under CPR 35.1 for permission to rely upon additional expert evidence. Nor was it concerned with identifying the circumstances in which a specialist life expectancy expert should be instructed. The issue before the Court was not one of admissibility or case management but of evaluation of the evidence already before it.

13. Accordingly, whilst *Royal Victoria Infirmary* establishes the potential relevance and utility of statistical and epidemiological evidence in the assessment of life expectancy,

it does not determine the question which arises on the present application. In particular, it does not answer whether such evidence is reasonably required for the purposes of CPR 35.1.

Mays

14. The Defendant also relies upon *Mays*, which considered issues concerning life expectancy evidence against the backdrop of the approach adopted by the Court of Appeal in *Royal Victoria Infirmary*.

15. The decision illustrates that life expectancy assessments are not necessarily confined to the exercise of clinical judgment in the narrow sense. The court recognised that statistical material, mortality data and epidemiological evidence may legitimately contribute to the assessment of future longevity. In that respect, the case reflects the broader proposition that life expectancy may require consideration of matters extending beyond the expertise of any single medical specialty.

16. Mr Arney submits that *Mays* supports the proposition that life expectancy constitutes a legitimate area of specialist expertise and that evidence directed specifically to longevity may, in an appropriate case, contribute something distinct from the evidence of conventional clinicians. I accept that the decision lends support to that proposition.

17. Nevertheless, the case was, again, not concerned with the application of CPR

35.1. It was not an authority on the circumstances in which a specialist life expectancy expert should be permitted to give evidence. Nor does it establish that such evidence will ordinarily be required whenever life expectancy is in dispute.

Dodds v Arif

18. The parties each place considerable reliance upon the decision of Master Davison in *Dodds v Arif*. The decision is not binding upon me. It is, however, a carefully reasoned and influential judgment which has frequently been cited in subsequent cases concerning applications of this nature.

19. A central theme running throughout the judgment is that life expectancy is ordinarily a matter to be addressed through the clinicians whose expertise relates directly to the medical conditions giving rise to the issue. Questions of future longevity generally arise because of underlying injuries, illnesses or impairments, and the primary evidence concerning those matters will therefore ordinarily come from the relevant clinical experts.

20. Master Davison was plainly concerned that specialist life expectancy experts should not become a routine feature of serious injury litigation merely because they are capable of producing analyses which are more detailed or statistically sophisticated than those offered by clinicians. Such an approach would sit uneasily with the language of CPR 35.1 and

the principle that expert evidence should be restricted to that which is reasonably required.

21. At the same time, the judgment recognises that circumstances may arise in which specialist life expectancy evidence is justified. The examples identified by Master Davison include situations in which clinicians are unable to express

> an opinion on life expectancy, identify a need for specialist assistance, or where disputes concerning statistical methodology arise. In my judgment, those examples are properly understood as illustrations rather than rigid gateways. They identify circumstances in which a court may conclude that a genuine evidential need has been demonstrated. They do not displace the ultimate statutory question posed by CPR 35.1.

Chaplin v Pistol

22. Finally, I was referred to the decision of Jay J in *Chaplin v Pistol*. Like *Dodds*, it is a decision of a judge of coordinate jurisdiction and is therefore persuasive rather than binding. It is nevertheless of assistance because it concerned an application for specialist life expectancy evidence in circumstances where the proposed expert was said to offer a more sophisticated statistical analysis than that available from the existing clinical experts. The application was refused.

23. The significance of the decision lies in the distinction drawn by Jay J between evidence that may be useful and evidence that is reasonably required. The judgment recognises that specialist evidence may provide greater precision, more extensive engagement with statistical material and a more sophisticated analytical framework. However, the existence of those advantages does not, without more, satisfy the requirements of CPR 35.1.

24. The decision illustrates the importance of identifying whether the proposed expert is addressing a genuine evidential deficiency or merely providing an additional layer of opinion on matters already capable of determination through the existing evidence.

Conclusions on the Authorities

25. Taken together, the authorities establish a number of propositions. First, life expectancy may properly be informed by a combination of clinical, statistical and epidemiological evidence.

26. Secondly, specialist expertise directed to life expectancy may, in an

appropriate case, provide valuable assistance to the court.

27. Thirdly, neither *Royal Victoria* nor *Mays* was concerned with an application under CPR 35.1 for permission to adduce

further expert evidence, and neither authority therefore determines when such evidence becomes reasonably required.

28. Fourthly, *Dodds* and *Chaplin* emphasise that the critical inquiry remains one of necessity rather than desirability. The fact that evidence may be useful, sophisticated or capable of providing greater precision does not, without more, satisfy CPR 35.1.

29. Accordingly, the issue before me is not whether the proposed evidence of Dr Brooks may assist the court. The issue is whether, in the particular circumstances of this case, that evidence has been shown to be reasonably required for the fair determination of the proceedings.

The Existing Expert Evidence

30. The Defendant's application falls to be determined against the background of a substantial body of expert evidence already obtained by the parties in the fields of neurology, rehabilitation medicine and neuropsychiatry.

The Neurological Evidence

31. The neurology experts are Dr Liu on behalf of the Claimant and Dr Crawford on behalf of the Defendant.

32. Following their discussions the neurologists produced a joint statement dated 14 January 2026 in which they reached substantial agreement regarding the effect of the traumatic

brain injury upon the Claimant's future longevity. At paragraph 9 of that statement they say, in terms of life expectancy:

"*They agree that her life expectancy has not been significantly affected by the index traumatic brain injury itself, unless she develops epilepsy.*

They defer to other experts regarding the impact on her survival through nonneurological factors"

33. After being asked for further clarification in relation to his joint report Dr Liu responded by letter dated 18 September 2026. He maintained the opinion previously expressed in the neurologists' joint statement that the Claimant's life expectancy had not been significantly affected by the index traumatic brain injury itself. He referred to his earlier reports and explained that, in his view, the Claimant had made a good neurological recovery, exhibited no neurological gait abnormality and no neurological signs in the lower limbs. He also addressed the literature relied upon by Dr Brooks. Whilst accepting the relevance of that body of research, he considered that the Claimant's presentation compared favourably with the cohorts identified within it and that, properly interpreted, the literature did not support any material reduction in her life expectancy. He further relied upon earlier work by Dr Brooks

which, in his view, supported the proposition that individuals who had recovered to the extent demonstrated by the Claimant might be expected to enjoy essentially normal life expectancy. Dr Liu accepted that the development of post-traumatic epilepsy could affect longevity and suggested that, were epilepsy to develop, a reduction of approximately one to two years might be anticipated. However, in circumstances where the Claimant remained seizure-free, his opinion remained that, from a neurological perspective, her life expectancy was unaffected. He concluded by expressing the view that assessments of life expectancy should principally be undertaken by clinicians with experience of the relevant medical conditions and a detailed
understanding of the individual patient.

34. Dr Crawford likewise provided a further response concerning life expectancy, by letter dated 25 September 2026. She maintained the position reached in the neurologists' joint discussions and agreed with the further reasoning and conclusions reached by Dr Liu in his of 18 September 2026. She goes on to specifically agree with Dr Liu that the use of Brooks data overestimates the Claimant’s potential reduction in life expectancy as a result of the traumatic brain injury. However, in her view, it is additional factors such as medical, psychological, psychiatric, lifestyle that could be responsible for a reduction in life expectancy; but that those are outside a

neurologist's area of expertise and she defers to an expert in life expectancy. She summarises her letter by saying (1) that there is some statistical support for a reduction in the Claimant's life expectancy due to the TBI, (2) she is not qualified to quantify that reduction deferring to a life expectancy expert, and (3) other factors (such as obesity)

may reduce the Claimant's life expectancy, but these fall outside her expertise and she again defers to a life expectancy expert.

The Rehabilitation Evidence

35. The rehabilitation medicine experts are Dr Anwar, for the Claimant, and Dr Singh, for the Defendant. They both produce a joint report date 10 January 2026 in which they are both agreed in relation to life expectancy, saying:

"*….There is a 1-2% epilepsy risk and that if seizures were to develop at this late stage, they are likely to be manageable on medication. Both experts also use the same methodology to calculate a small reduction in life expectancy of around 3 years. They both note the importance of other factors in life expectancy, such as previous comorbidities, including obesity*".

36. In a supplementary letter dated 24 September 2026, Dr Singh elaborated upon his opinion concerning life expectancy. He

maintained his view that the claimant's life expectancy was likely to be reduced by approximately ten years overall, comprising a reduction of around three to four years attributable to the traumatic brain injury and a further five to six years attributable to longstanding obesity. He considered the evidential basis linking obesity to reduced life expectancy to be strong and observed that the claimant's obesity and dietary habits placed her at increased risk of developing diabetes, a condition which itself is associated with a substantial reduction in life expectancy. Dr Singh also referred to published literature indicating that disruptive or challenging behaviour and mental health disorders are associated with increased mortality and reduced life expectancy. He noted the claimant's longstanding history of confrontational behaviour, criminal charges and

mental health difficulties, and expressed the view that those matters were likely to justify a further reduction in life expectancy. He concludes by saying that *"Calculation of the overall reduction in LE is difficult as most experts specialise in one subject area. However there are experts in life expectancy and statistics and it would be useful to seek an assessment by such an expert to try and provide a composite assessment of the various pathologies and impairments and hence an overall LE"*.

37. Dr Anwar's response to the question of life expectancy was provided by email dated 8 September 2026 and was admirably short. The body of what he says is worth setting out in full:

> *"Dr Singh and I used the same published methodology from Brooks et al. It estimates life expectancy after traumatic brain injury by reference to factors most closely associated with mortality risk, particularly mobility and feeding ability. She falls in the fully mobile, normal-diet category.*
>
> *The Brooks table indicate a life expectancy of 18 years for a 60-year-old in that category, compared with 21.8 years for the general population. We then considered current ONS data for a 65-year-old woman, together with existing comorbidities, including obesity. This produced an estimated reduction of around three years.*
>
> *The calculation reflects the statistical effect of traumatic brain injury on life expectancy."*

The Neuropsychiatric Evidence

38. The parties have also obtained expert evidence in the field of neuropsychiatry from Dr Achinivu (instructed by the Claimant) and Professor Fahy (instructed by the Defendant). They have produced a joint expert report dated 25 January 2026. In that report the neuropsychiatric experts reached substantial agreement concerning the Claimant's psychiatric condition. Of particular relevance for present purposes, they agreed that the

Claimant had not developed posttraumatic stress disorder. Although some issues remained in dispute, the joint evidence does not identify psychiatric conditions of the kind that are sometimes relied upon as independent drivers of significantly reduced life expectancy.

39. Further clarification was subsequently sought from Dr Achinivu concerning the relevance of psychiatric factors to life expectancy. Dr Achinivu's response was unequivocal. Having considered the Claimant's psychiatric history, both before and after the accident, he expressed the view that there were no psychiatric reasons which would be expected to reduce her life expectancy.

40. Dr Achinivu also addressed certain studies relied upon by Dr Brooks. In particular, he questioned the applicability to the Claimant of studies involving cohorts suffering from conditions such as PTSD and personality disorders, observing that the Claimant did not suffer from those conditions. The importance of this evidence lies not in whether it ultimately proves correct. Rather, it illustrates that aspects of the analysis proposed by Dr Brooks depend upon underlying clinical assumptions which are themselves the subject of expert evidence and which may require determination by the trial judge.

The Position Revealed by the Existing Evidence

41. Standing back from the detail, a number of features emerge from the existing expert evidence.

42. First, life expectancy has already been considered by experts from a number of relevant disciplines.

43. Secondly, the experts have approached the issue from different professional perspectives. The neurologists have addressed the consequences of the traumatic brain injury from a neurological standpoint. The rehabilitation experts have considered the issue in the context of the Claimant's broader functional presentation and overall health. The neuropsychiatric evidence addresses psychiatric factors said to bear upon future mortality.

44. Thirdly, the evidence identifies issues which may reasonably be said to extend beyond the expertise of any single discipline, including the interpretation of epidemiological studies, the quantification of mortality risk and the interaction between a number of factors said to affect longevity.

45. Fourthly, and importantly, no expert has undertaken the overarching life expectancy assessment proposed by Dr Brooks. No expert has sought to draw together, within a single analysis, the various neurological, psychiatric, rehabilitative and epidemiological considerations relied upon by the Defendant.

The Proposed Evidence of Dr Brooks

46. The proposed evidence of Dr Brooks must be considered against the evidential background outlined above. Dr Brooks is not instructed as a neurologist, psychiatrist or rehabilitation physician. Nor does he purport to offer opinions

    within those disciplines. Rather, his proposed role is to undertake an assessment of the Claimant's overall life expectancy drawing together a number of matters which have been addressed separately within the existing expert evidence.

47. As appears from his report, Dr Brooks considers epidemiological literature concerning traumatic brain injury, mortality studies, comparator populations and statistical modelling. He also addresses the effect upon life expectancy of a number of co-existing factors relied upon by the Defendant, including obesity and matters arising from the Claimant's broader medical history.

48. He further considers the question whether life expectancy should be assessed by reference to current life tables or projected life tables and expresses views concerning the relevance of those approaches to claimants who have sustained traumatic brain injuries.

49. Ultimately, Dr Brooks seeks to undertake what the Defendant describes as a composite assessment of the various factors said to affect the Claimant's longevity and to provide an overall opinion as to her life expectancy.

Discussion

50. The Defendant submits that bespoke life expectancy evidence from Dr Brooks is reasonably required because none of the experts presently instructed is able to undertake the composite assessment of life expectancy which, he says, is necessary in a case of this nature. Reliance is placed upon Dr Brooks' opinion that an assessment of life expectancy requires consideration of the interaction of multiple medical conditions and risk factors, together with the observations

    of Dr Crawford and Dr Singh concerning the potential utility of specialist life expectancy evidence. The Defendant further relies upon the observations of the Court of Appeal in *Royal Victoria* concerning the value of an
    interdisciplinary approach to questions of life expectancy.

51. I have carefully considered those submissions. Dr Brooks plainly possesses expertise which differs from that of the existing experts and may be capable of assisting the court on matters falling within his field of specialism. Equally, life expectancy is potentially a significant issue in this litigation. Those matters do not, however, determine the application. The question for the court is whether the proposed evidence is reasonably required for the fair resolution of the proceedings. In my judgment, it is not.

52. The starting point is that the court already has available, or will have available, expert evidence addressing the medical consequences of the Claimant's injuries and conditions. The relevant clinicians are able to express opinions concerning the effect of those conditions within the scope of their respective expertise, including whether they are likely to have any impact upon longevity. It is true that none of those experts purports to undertake the type of composite life expectancy assessment advocated by Dr Brooks. However, the absence of such an exercise does not, in my judgment, constitute an evidential lacuna requiring the introduction of a further expert discipline.

53. On analysis, the Defendant's complaint is not that relevant evidence is unavailable to the court. The clinicians are able to express opinions concerning the medical consequences of the Claimant's various conditions and any implications for longevity falling within their respective disciplines. Rather,

    the Defendant's complaint is that no existing witness undertakes the final synthesising exercise advocated by Dr Brooks. Whether the absence of that exercise justifies the instruction of a further expert is the central question raised by this application.

54. In my judgment, the application identifies a gap in analytical methodology rather than a gap in available evidence. The existing experts can provide the evidential building blocks necessary for determination of the issue. What is sought is an

additional expert whose role would be to assemble and interpret those building blocks by reference to statistical and epidemiological material. Whether such an exercise may be useful is not the question. The question is whether it is reasonably required within the meaning of CPR 35.1.

55. That synthesis, moreover, depends upon the resolution of disputed clinical issues which must in any event be determined on the basis of the existing expert evidence. The opinions expressed by Dr Brooks do not stand
independently of the clinical findings which the court must first make. Rather, they proceed from them.

56. In that regard, I do not consider that the evidence of Dr Crawford or Dr Singh takes the Defendant's case materially further. Both recognise the potential value of specialist life expectancy evidence and the limits of their own disciplines. However, neither suggests that the court is incapable of determining the issue without such evidence. Their observations are directed to the possible utility of further expert input, not to its necessity.

57. The Defendant also relies upon what are said to be limitations in Dr Liu's treatment of life expectancy. In particular, it is submitted that Dr Liu's opinion

that life expectancy has not been “significantly affected” by the traumatic brain injury leaves unclear whether he accepts some

reduction in life expectancy and, if so, the extent of any such reduction. It is further submitted that Dr Liu does not undertake the broader assessment of multiple interacting risk factors advocated by Dr Brooks.

58. I accept that Dr Liu's evidence is directed to matters falling within his own clinical expertise and does not purport to provide the broad statistical assessment proposed by Dr Brooks. However, that does not, in my judgment, demonstrate that a separate life expectancy expert is reasonably required. Even assuming that the criticisms advanced of Dr Liu are well-founded, they do not lead naturally to the conclusion that a life expectancy expert is required. If clarification of Dr Liu's neurological opinion is required, that clarification would ordinarily be sought from the neurologist himself. The perceived limitations of one expert's evidence do not, without more, justify the introduction of an entirely new expert discipline. Nor does the fact that Dr Liu has not undertaken the form of composite analysis advocated by Dr Brooks establish an evidential lacuna. Rather, it reflects the limited purpose for which the existing clinicians were instructed. The question remains whether the court has available the evidence necessary fairly to determine the issue before it. For the reasons already given, I am satisfied that it does.

59. Nor do I consider that *Royal Victoria* assists the Defendant to the extent argued. I accept that the Court of Appeal recognised

the value of combining clinical and statistical perspectives when considering issues of life expectancy.

However, I do not read that decision as establishing that specialist life expectancy evidence is required whenever life expectancy is disputed. The Court of Appeal was concerned with the evaluation of evidence before the trial court. It was not addressing the distinct case-management question arising under CPR 35.1. There remains an important distinction between evidence which may assist the court and evidence which is reasonably required, and *Royal Victoria* does not remove that distinction. The fact that an interdisciplinary approach may be desirable in a given case does not mean that every discipline capable of providing assistance satisfies the test of reasonable necessity under CPR 35.1.

60. The Defendant also relies upon a number of methodological issues which Dr Brooks considers require specialist statistical expertise, including questions concerning the use of current as opposed to projected life tables and the interpretation of epidemiological data. I accept that Dr Brooks may be able to provide assistance on such matters. However, the existence of potentially useful statistical questions does not establish that bespoke life expectancy evidence is reasonably required. The significance of those issues depends upon prior findings regarding the nature and extent of any reduction in life expectancy arising from the Claimant's various conditions,

matters which fall within the expertise of the clinicians already instructed.

61. Standing back and considering the matter in the round, I am not persuaded that the proposed evidence is reasonably required for the fair determination of the proceedings. The court will have available expert evidence concerning the medical consequences of the Claimant's injuries and conditions. It will be for the trial judge to evaluate that evidence, resolve any conflicts within it, make

the necessary findings of fact and reach conclusions regarding life expectancy. The proposed evidence may provide an additional perspective and may assist the trial judge in the evaluation of the existing material. That, however, is not the test. CPR 35.1 requires the court to be satisfied that the evidence is reasonably required for the resolution of the proceedings. Having considered the matter in the round, I am not so satisfied.

Delay and Case Management

62. In light of my conclusions concerning CPR 35.1, it is unnecessary to determine the application by reference to delay and trial management considerations. Nevertheless, because the issue was fully argued, I shall address it briefly.

63. The Defendant submits that the need for specialist life expectancy evidence emerged only once the parties' positions

had crystallised and that the application was pursued reasonably once it became apparent that settlement would not be achieved. I do not accept that submission in its entirety.

64. The matters upon which the Defendant now relies were not newly discovered following the joint settlement meeting. The neurological evidence, the rehabilitation evidence, the issues concerning obesity, and the existence of epidemiological literature said to bear upon life expectancy were all matters known to the Defendant well before that stage. Indeed, the central premise of the present application is that the existing expert evidence was incapable of addressing adequately the life expectancy issue. If that premise is correct, it is difficult to see why the need for specialist evidence only became apparent after the outcome of settlement negotiations was known.

65. In reality, the Defendant appears to have taken no substantive steps to obtain specialist life expectancy evidence until after it became apparent that the case would not settle. Whilst that may have been a perfectly understandable forensic or commercial decision, it is not the same thing as saying that the need for such evidence only then arose.

66. It was also submitted on behalf of the Defendant that the Claimant could and should have obtained responsive evidence at an earlier stage. I do not accept that criticism. Until the court gave permission for the Defendant to rely upon specialist

life expectancy evidence, the Claimant had no reason to assume that such evidence would form part of the expert evidence at trial. The Claimant cannot fairly be criticised for failing proactively to obtain responsive evidence to expert evidence which had not yet been admitted and in respect of which no permission had been granted.

67. Nor, in my judgment, can the consequences of that timing properly be laid at the Claimant's door. If the Defendant elected to defer obtaining specialist life expectancy evidence until after the outcome of settlement negotiations was known, it must accept the case-management consequences which flow from that decision. Were permission now to be granted, elementary fairness would require the Claimant to have a proper opportunity to respond. The probability is that further expert engagement, consideration of responsive evidence and the instruction of an equivalent expert by the Claimant, would all follow. I can predict, with some confidence, that this would most likely lead to the loss of the trial date.

68. Had I concluded that the evidence of Dr Brooks was reasonably required within the meaning of CPR 35.1, these considerations, whilst remaining powerful factors militating against the grant of permission, might not, by themselves, have justified refusing permission. However, having concluded that the proposed evidence is not reasonably required, the chronology of the application, the lateness with which

specialist evidence was pursued, and the potential disruption to a long-established trial date all reinforce the conclusion that permission should not be granted.

Conclusion

69. For all of the reasons given the Defendant's application falls to be dismissed.

70. Following the circulations of the draft of this judgment the parties have agreed terms and seek, accordingly, to utilise the first day of the trial due to commence on 2 November 2026 to seek approval of the sums in question. It is anticipated that an application for anonymity will be made on behalf of the Claimant at that hearing. In the event that such application is successful this judgment will also need to be anonymised accordingly.