Neutral Citation Number: [2018] EWHC 3276 (QB)

Case No: HQ16C04073

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 27/11/2018

Before :

MASTER THORNETT

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Between :

MISS SHARRON DENISE HALL	**Claimant**
- and –	
DERBY TEACHING HOSPITALS NHS FOUNDATION TRUST	**Defendant**

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Mr Haines (instructed by Shoosmiths LLP) for the Claimant
Miss Clare Elliott (instructed by Browne Jacobson) for the Defendant

Hearing dates: 18 October and 15 November 2018

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JUDGMENT

Master Thornett :

1. This is my reserved judgment on the Claimant's Application dated 4 July 2018 to have permission to rely upon neurosurgical evidence and for directions in consequence, including an increase to the Claimant's previously budgeted costs. The Application extended over two hearings, the first on 18 October 2018 and the second on 15 November 2018.

The need for two hearings and a reserved judgment in such an Application is unusual. Typically, Applications are heard and decided at the same hearing and very often in the context of a Case Management Conference dealing with a variety of directions. Such an exercise occurs on virtually a daily basis within the Masters' corridor.

Unfortunately, this case did not proceed in this way. The experience from it illustrates the importance of the following points to the party applying.

1.1 Correctly identifying any revised decision or relief they pursue by the time of the hearing rather than as sought when the Application was drafted. Any change of position or development in the Application in the period between issue and the hearing needs to be made very clear both to the Respondent as soon as possible preceding the hearing and to the court at the very commencement of the Application.

1.2 Drawing to the court's attention to the relevant evidence relied upon. Litigant's should not assume that judges passively acquire an encyclopaedic knowledge of hearing bundles by some form of osmosis because materials appear in the hearing bundle as delivered. Particularly in the Masters' List, there is no allocated reading time for applications unless, by way of prior agreement and direction by the Master, reading

time has been incorporated into the Master's diary. This observation is relevant to any hearing but even more so one where a party's position or evidence has changed since the date when the Application was drafted. Plainly, a busy judge is entitled first and foremost to look to the Application for an introduction to the case and then to the Applicant's advocate at the hearing for guidance and assistance.

1.3 Providing succinct Case Summaries or skeleton arguments as set out the most relevant information as focuses upon the Application as it stands at the date of the hearing. Tracts of information repeating the pleadings or narrating factual or technical issues in the case by way of general introduction are rarely helpful. Conversely, a review of the parties' most up to date respective arguments in respect of the hearing in question and an introduction to what documents, if time permits, are the more essential to read in advance of the hearing is very helpful.

2. This case also illustrates how a party that seeks to implement steps in advance of obtaining permission from the court clearly takes a risk that they may not be successful on their application. The greater a party's presumptive preparation, therefore, the more complex, time consuming and expensive it may ultimately prove for that party subsequently to reverse matters. Given such risk, at least to canvass the proposed course of action to an opponent would seem good practice, whether or not it is realistically anticipated there might be agreement. On any view, it is utterly crucial to be entirely clear and transparent to the court from the outset of the hearing as to what steps have been taken on a presumptive basis.

3. The claim concerns negligence performance of a laparoscopic cholecystectomy on 30 July 2013. Because the Claimant's bile duct was negligently damaged during the operation, she underwent subsequent invasive open surgery. The Defendant admits

that had the laparoscopic cholecystectomy been performed to an acceptable standard, the subsequent surgery could have been avoided. The Claimant has been left with a variety of symptoms including severe ongoing abdominal pain around the incision point of the surgery.

3. At the date of issue, the Application was supported by a witness statement dated 4 July 2018 from the Claimant's solicitor, Ms Natasha Read. Ms Read describes the variety of the Claimant's ongoing symptoms including abdominal pain. At Paragraph 11 the statement describes a problem the Claimant has with her right foot as causes weakness and instability. Ms Read comments how the cause of this symptom had been considered to be beyond the expertise of the Claimant's appointed experts in psychiatry, pain management and general surgery and so permission had been obtained at a CMC in January 2018 for the Claimant to rely upon further expert evidence from a neurologist. The neurologist had recommended a full spine MRI scan. The MRI scan identified two spinal lesions, one thoracic (T6) the other cervical (C1).

4. In response to the MRI scan, the Claimant's neurologist Dr Gardner-Thorpe remarked in his letter dated 28 June 2018 that it was possible that one or both of the lesions could be contributing to the right lower limb symptoms although "this causal link seems unlikely". He considered alternative explanations, such as the rare condition of paroxysmal kinesiogenic choreoathetosis, although adding that the Claimant's description of symptoms "did not quite fit the classical picture of this condition". Alternatively, psychogenic explanation might prove relevant "after physical causes had been ruled out".

Balancing the variety of potential explanations, Mr Gardner-Thorpe commented :

"In the absence of input from a neurosurgeon to complement my knowledge I am unable to conclude which of these potential causes is most likely on a balance of probabilities and where the symptoms are related to the surgery or not. I would strongly recommend the instruction of a neurosurgeon in this case to help resolve this important issue and to consider whether a spinal lesion is relevant to Miss Hall's reported symptoms".

Mr Gardner-Thorpe explains that a neurosurgeon rather than a neurologist would be responsible for treating such lesions. Neurologists have more limited experience in this particular area.

5. A letter dated 2 July 2018 from the Claimant's pain medicine expert, Dr Harrison, in support of the proposed instruction of a neurosurgeon was also annexed to Ms Read's statement. Dr Harrison remarks that "Were I to have a patient with such a finding, I would be seeking the opinion of a neurosurgeon to give an opinion on the significance of [the MRI scan] in relation to their symptoms, and would consider instructing a neurosurgeon to comment….".

Plainly, this letter had been commissioned in order to support the Claimant's Application as issued a few days later.

6. Ms Read concludes her first statement by referring to potential input from a treating neurosurgeon at Queens Medical Centre in Nottingham and submits that "Without the requested neurosurgical evidence her ability to prove essential elements of causation and quantum would be hindered significantly".

7. Presumably only following the drafting of her Application and in anticipation of a hearing date, the Claimant proceeded to instruct a Consultant Neurosurgeon, Professor Marks, as a proposed medico-legal expert in the claim. He produced two reports for the Claimant.

8. The first, dated 11 September 2018 provides a review of the Claimant's current medical evidence.

In respect of the report from Dr Harrison, Pain Medicine, Professor Marks draws upon Dr Harrison's view that the Claimant's excess weight is a factor in her back pain but a further feature is weakened core muscles as a result of the surgical incision. He notes Dr Harrison excludes any causal relationship between the paravertebral block injections the Claimant received and low back pain.

Professor Marks notes that Dr Gardner-Thorpe did not consider the C1 lesion to be relevant to right lower limb symptoms and that the contribution of the T6 lesion unlikely but that taking neurosurgical opinion would be "wise". Other exclusions of relationship between the MRI findings and both degenerative changes and right lower limb symptoms as expressed by Dr Gardner-Thorpe are noted.

Professor Marks summarises the psychiatric report from Dr Turner.

9. Having considered the MRI scan, Professor Mark describes the mass lesion at T6 as a relatively common and almost always benign. The radiology depicts of form of nerve sheath tumour that might benefit from scanning from time to time. He concludes [5.5.2] that he does not believe "that there are any radiological findings that can explain Miss Hall's right sided leg problems". Her low back complaint is "almost certainly" underwritten by constitutional degenerative changes and none of the

radiological abnormalities within the cervical, thoracic or lumbar regions were "caused or contributed to by the negligent surgery on her extra-hepatic biliary tree" [5.5.3].

At 5.5.5 Professor Marks thought that the nerve sheath tumour is likely to become symptomatic within the next 5 years, depending upon how the tumour grows. A recovery period of approximately 3 months would follow the likely surgery and the Claimant might need care and assistance for approximately 2 months. This observation is, of course, in respect of a non-negligent surgery feature.

Professor Marks considered that the combination of weight gain and loss of abdominal core strength had accelerated constitutional degenerative back pain but did not offer an opinion as to the respective contribution of these elements [5.6].

He thought the right leg symptoms could be related to facet joint dysfunction but would prefer to examine first. Aside of this possible diagnosis, Professor Marks thought it more likely than not that the right leg symptoms "are related to chronic abdominal pain as suggested by Dr Harrison compounded by psychiatric issues as suggested by Dr Turner".

In conclusion "(T)he abnormalities in the cervical and thoracic regions of this lady's spine on the MRI scan from June 2018 do not explain the symptoms she has in her right leg. Miss Hall has constitutional degeneration of the lumbar spine which was asymptomatic prior to the Defendant's admitted negligence. This degenerative condition has been exacerbated and accelerated by the sequelae of the breach of duty, namely the weight gain and loss of abdominal muscle strength" [5.9].

At the end of his report, as had obviously been commissioned from a desire for neurosurgical input, Professor Marks states at Para 5.10 :

"For the avoidance of doubt, none of the changes within the spine seen radiologically can be attributed to the index negligence operation on the extra-hepatic biliary tree".

10. Professor Marks' second report, dated 1 October 2018, follows an examination of the Claimant on 25 September 2018. He noted on examination the Claimant is 5 feet tall and weighs 95kg. He concluded that low back pain was "a combination of facet joint and sacroiliac joint dysfunction plus the exacerbation and acceleration of the underlying constitutional degeneration (a sequalae of the index surgery)" [8.7]. "Clinical examination does not explain the basis of this lady's right leg symptoms, that is to say the pain which begins in her foot and radiates proximately which occurs on an episodic basis" [8.8] and neither did the MRI scan [8.13].

11. It seems very clear from these reports that neurosurgical input has failed to establish any neurosurgical link between the right lower limb symptoms that led to its initiation and the negligent surgery. Further, they exclude the relevance of the lesions also noted in the MRI scan as relevant to negligent surgery. Professor Mark's view was that "the right leg symptoms are related to chronic abdominal pain as suggested by Dr Harrison, compounded by psychiatric issues as suggested by Dr Turner". In expressing this view, Professor Marks is clearly deferring to the pre-existing disciplines of pain medicine and psychiatry. Permission for a neurosurgeon to offer passing comment on other disciplines would not be required or justified.

12. Although the MRI scan does not establish any link to the negligent surgery, it is correct that, in consequence to Professor Mark's opinion how the T6 lesion might lead to future surgery and treatment, this could oblige the Claimant to offer a

comparatively modest credit to her future damages claim. Given the need to limit expert evidence and to achieve proportionality in the evidence called at trial, however, it is difficult to see why this justifies expert opinion being permitted on the point.

13. Considering Professor Mark's reports in isolation, I do not follow what, if anything, they add from the viewpoint of his particular discipline.

14. The Defendant opposed the Claimant's application, for reasons principally set out in the witness statement dated 15 October 2018 from the Defendant's solicitor, Jennifer Fagin. It is clear from this statement that the Defendant's understanding has been that the Claimant seeks to justify further expert input owing to intermittent symptoms of weakness in her right foot and the lesions identified in the MRI scan. As at the date of the statement, the Defendant had asked its own neurologist, Mr Simpson, to comment as to whether neurosurgical evidence was required. He did not think it necessary, believing the radiological evidence to be clear in excluding any causal relationship between the right leg symptoms and the surgery. Ms Fagin comments how permission to rely upon Professor Marks will increase costs despite there being, in the Defendant's submission, no justification for permission being given.

Ms Fagin remarks that although the Claimant was supposed to disclose her medical evidence by 6 July 2018, it was not disclosed until 17 September 2018. As at the date of her statement, Ms Fagin remarks how the Defendant has yet to review the Claimant's expert evidence as disclosed and to take instructions. From this, therefore, it is clear that any challenge as to the evidential status of those reports (for example, should they contain references to an expert report for whom permission has not been given) is reserved.

However, having considered the reports from Professor Marks, Ms Fagin is clear in submitting that they add nothing .

15. Shortly before the first hearing, Ms Read served on behalf of the Claimant a second witness statement, dated 12 October 2018. This reiterated her previous position but formally annexed the two reports as had since been obtained Professor Marks. Ms Read submitted permission to rely upon Professor Marks was reasonably required because Professor Marks had:

15.1 Confirmed that the spinal lesions were unlikely to be responsible for the Claimant's right leg symptoms. Whilst this might been seen as somewhat of a contradiction of her previous stance, Ms Read suggests that evidence to establish this confirmation assists the parties so as to exclude the lesions as a potential physical cause and so are unrelated to the admitted negligence;

15.2 Excluded other potential neurosurgical/ neurological causes of the leg symptoms, on the same basis of justification as previously;

15.3 Opined that the Claimant's reported back pain is likely to be caused by an acceleration and exacerbation of constitutional degenerative changes in the lumbar spine associated with the loss of core abdominal strength and weight gain arising from the surgery. There is no discussion offered why a neurosurgeon is required on this point in addition to the neurologist already permitted;

15.4 Suggested that right leg symptoms are related to chronic abdominal pain. There is no discussion on this point how Professor Mark's discipline is apparently relevant;

15.5 Considered that the thoracic lesion is likely to be a tumour that will become symptomatic in about 5 years' time and will require surgical removal. The risks of

such surgery and the period of necessary recuperation is relevant to the Claimant's Special Loss.

16. Ms Read's overview of Professor Mark's reports seems clearly to further the premise of the Application that permission for neurosurgical evidence is still required to inform the current litigation even if, as the reports as now obtained make clear, so as to exclude a neurosurgical diagnosis rather than provide one. So, the draft Order relied upon throughout and as annexed to the Application refers to granting such permission and then extends time for service of the Claimant's expert medical evidence.

17. The date for that extension (as at 4 July 2018) was proposed to be 17 September 2018. The fact the first hearing of this application on 18 October 2018 was after this date is not of itself remarkable, in that hearings are sometimes unavoidably listed on a date after the sequence of directions proposed in the Order. For reasons that follow, in this case the date in fact had a far greater significance and consequence.

18. The hearing of Claimant's application was listed on 18 October 2018 for 30 minutes at 12.30pm. The hearing in fact lasted for over an hour and I sat into lunchtime. Save for the Schedule of Loss dated 14.09.18, the hearing bundle did not include the pleadings. It included the Application, two witness statements of the Claimant's solicitor Mr Read in support, five medical reports from experts for whom the Claimant had permission and had by then been disclosed, the two reports of Professor Marks, the Claimant's 24.03.18 witness statement and materials in support of proposed adjustments to previous budgets. It did not include the Defendant's witness statement from Ms Fagin and so the Defendant was obliged to provide that to the court separately.

19. At the commencement of the hearing, upon invitation by Mr Haines, Counsel for the Claimant, I indicated that I had read the Application, the supporting witness statements of Ms Read, the witness statement from the Defendant's Solicitor Ms Fagin in reply and the two reports of Professor Marks as relevant to the Application. I made expressly clear that I had not otherwise read the bundle in detail. I made clear that that I did not have an "encyclopaedic knowledge" of the case in response to Mr Haines opening the Application with remarks that assumed I had a close knowledge of all of the evidence the Claimant relied upon.

20. Early into the hearing, I invited Mr Haines to explain what purpose could now be identified for having permission to rely upon Professor Marks. I questioned whether matters had not moved on from the position contemplated at the time the Application was first drafted and so had not the purpose as originally intended fallen away. Drawing upon the stance taken in Ms Read's second statement, Mr Haines sought to illustrate that because the proposed evidence excluded certain diagnoses, the evidence of Professor Marks would enable the existing experts to focus further from the viewpoint of their own particular disciplines. I put to Mr Haines that this was a different sort of application to that predicated by Ms Reed in her first statement and asked whether this revised approach, that is one that conceded the Claimant no longer sought to rely upon neurosurgical evidence to prove symptoms referable to the negligent surgery but instead to exclude them, had been clearly stated and the revised intention explored with the Defendant before proceeding to this as an opposed hearing. I was not taken to any correspondence by Mr Haines in this regard.

21. Having heard from the Defendant, who maintained its position that there simply was no place or call for neurosurgical evidence, I remained unconvinced that formal permission for Professor Marks was required and so there was no justification in revising the parties' budgets. I suggested that it might be more proportionate in costs and progressive efficient to put to the Defendant in correspondence whether it agreed with the propositions as to exclusion as the Claimant was by now able to set out in principle. Until the Defendant's position was known, again in principle, it was premature to decide whether Part 35 permission to rely upon neurosurgical evidence was required even if now for a different reason to that originally contemplated. Professor Mark's reports could therefore still be a discussion point between lawyers without having first to formally grant the Claimant permission to rely upon Professor Marks under Part 35.

22. Mr Haines described it as potentially "disastrous" to have a report "doing the rounds" but for which permission had not been given. Nonetheless, in response to my observation that the distillation of the proposed new evidence was entirely capable of encapsulation by those representing the Claimant and considered by those representing the Defendant, Mr Haines accepted this could be attempted. I expressed the view that it was not implicit that such exercise unavoidably had to involve consultation with either side's experts, despite Mr Haines maintaining that he needed the written response of his experts. It was, in my view, no different to many cases where those representing can discuss the application or not of proposed expert evidence ; as happens in many cases without there being a report as already prepared to rely upon.

23. The hearing therefore adjourned on the understanding there would be a process of discussion and proposition between the parties to see if a cheaper and more concise application of this newly emerged evidence, if any, could be achieved rather than following the Claimant's proposals for formal Part 35 permission with its consequential costs implications.

24. The above summary of the first hearing follows a review of my notes and my having carefully listened to the recording of the hearing.

25. From this, I am quite clear that at no stage during the first hearing did the Claimant through her counsel Mr Haines ever make clear that she had, in fact, *already* put Professor Mark's reports to her existing experts. Therefore, this was no longer an application for permission to rely upon reports that, if so permitted, would then inform the existing experts. Quite to the contrary, the Claimant had already done this and the true application was to seek retrospective permission for the Claimant having done so. To adopt Mr Haines' expression, Professor Marks' reports had in fact already "done the rounds".

26. The second hearing on 15 November 2018 was listed for 90 minutes. Despite this longer time estimate, it similarly was not opened or pursued by the Claimant on, as I find should be so described, the correct basis.

The Claimant had in the interim period served upon the Defendant a sequence of written propositions essentially drawing upon Ms Read's summary of Professor Mark's reports as appear in her second statement. In response, the Defendant had either agreed with obviously uncontentious points [for example "There are no radiological findings that explain the Claimant's right sided leg symptoms" or "The Claimant should give credit within her Schedule of Loss for any loss of earnings or

care and assistance requirement caused by (future surgical removal of the tumour)"] or otherwise replied that the Claimant's propositions were not unreasonable but ultimately speculative. This was the Defendant's response to the Claimant's "credit point" about the Claimant potentially needing future surgery to the nerve sheath and to what extent it might reduce the Claimant's future loss claim.

Of perhaps more direct relevance to the existing medical disciplines, the proposition that constitutional degenerative back pain had been exacerbated by sequalae from the breach of duty (namely weight gain and loss of abdominal strength), the Defendant had replied that it had yet to receive its Pain Management evidence. Similarly, to the proposition that the right leg symptoms "are likely to be related to her chronic abdominal pain compounded by psychiatric issues" the Defendant replied it was unable to either agree or disagree because it had yet to receive either Pain Management or Psychiatric evidence.

None of these replies in my view supports an argument of there still being a need to introduce Professor Mark's evidence, even if so as to establish exclusion and to assist the existing disciplines.

27. Again without reference to what the Claimant's permitted medical experts were known already to have said in response to Professor Mark's reports, at the second hearing Mr Haines again sought to take me through the background how the neurosurgical reports had first been requested by Dr Gardner-Thorpe and the extent to which Professor Marks now enabled certain points to be excluded (the right leg symptoms) but supported a case that some of her symptoms could be the consequence of the surgery (e.g. aggravation of constitutional symptoms owing to increased weight). Mr Haines described the Defendant's responses to the propositions as

equivocal and so, in essentially still requiring the Claimant to prove matters, justified the Claimant still pursuing her application to rely upon Professor Marks.

28. The feature of the Claimant having already put Professor Mark's reports to her experts in fact only emerged during the submissions from Miss Elliott, Counsel for the Defendant, who made the point that even when Professor Mark's reports had been put to the Claimant's experts, it can be seen that it had achieved very little in response.

29. I gave Mr Haines what, by then, was the remaining 10-15 minutes of the hearing to specifically address what the Claimant's experts had had to say. In short, to develop the substance of what I am quite satisfied should have been the focus of the application from the very commencement of the first hearing.

30. Although noting what Mr Haines had to say in concluding the application, I have felt obliged to read through these reports independently owing to the short amount of hearing time Mr Haines had caused to be left.

31. The Claimant has permission to rely upon Mr McCloy, a Consultant and General Surgeon. In his 5 September 2018 report, he commented on the Claimant's condition as at 5 June 2018. At that date, therefore, he noted only that an MRI scan was planned in consequence to symptoms of weakness in the right foot. On the attribution of these symptoms, he described them as outside his area of expertise but that he did not believe they were likely to be related to the surgery. He deferred to neurological opinion.

32. In his second report dated 26 June 2018, the Claimant's Pain Management expert Dr Harrison refers to the leg weakness and comments how in his previous report (6 March 2017) he had considered the opinion of a neurologist was necessary. In this

report, Dr Harrison states how he remains "of that opinion and defer to the report of Dr Gardner-Thorpe". He notes the recent MRI scan and the two lesions. He considered the cervical lesion to be "probably of no consequence" but, in respect of the thoracic lesion, he would "defer to the opinion of a neurosurgeon concerning the significance of this in relation to the Claimant's symptoms".

33. There is nothing here that draws upon Professor Mark's evidence, nor I am satisfied might there be.

34. The "Supplemental Psychiatric Report" from the Claimant's Dr Turner, is dated "August 2018". No specific date is stipulated but the open page of the report makes clear it was prepared in consequence to a re-examination of the Claimant on 4 June 2018. Despite this, it is odd to note that within the opening pages listing "Sources of Information" Dr Turner finally lists a "Report prepared by Prof P Marks, Consultant Neurosurgeon". The word "report" is in the singular and so must refer to Professor Mark's first report dated 11 September 2018. Therefore, either Dr Turner failed sufficiently and correctly to update his report following sight of the first report or he saw an earlier version of Professor Mark's first report sometime during August 2018.

35. More express is the following paragraph within Dr Turner's report:

"26. I have been asked to comment on the continuing right leg symptoms affecting Miss Hall, and note from the reports of Dr Gardner Thorpe and Prof Marks that the potential but unlikely organic causes outlines include paroxysmal kinesigenic choreoathotosis or a facet joint problems. I note consideration has been given, by these experts, as to the possibility of there being a psychological basis, as a diagnosis of exclusion…".

Accordingly, in the following paragraph Dr Turner comments that on the basis the court accepts the Claimant's description of her symptoms "and in the absence of a physical or organic cause of Miss Hall's right leg symptoms being identified, a reasonable explanation is that there is a significant psychological component. If there is a psychological component to this symptom it is likely to be attributable to her overall pain state, sense of frustration and depression which would derive from the nature of the index event".

From this it seems clear that Dr Turner does not particularly draw from Professor Marks' input but as much Dr Gardner-Thorpe's originally expressed doubt whether there was any relationship between the MRI scan and the symptoms the Claimant thought might be surgery related. So whilst Professor Mark's conclusions might well have assisted Dr Gardner-Thorpe in concluding his own position, they go no further than that by the time of their introduction to Dr Turner.

36. The Claimant's care report from Ms Campbell is similarly opaquely dated "September 2018" but clearly post-dates Professor Mark's first report because, within Appendix 2 as "List of documents I have studied", the "Report of Professor Marks" is listed. Ms Campbell confirms in the opening pages of her report that she had had a second assessment some five months' earlier in April 2018. A reasonable inference therefore is that Ms Campbell must have completed her report to some degree following her assessment visit in April 2018 but then was provided with the first report of Professor Marks.

At Paragraph 5.10, Ms Campbell refers to Professor Mark's opinion that the lesion(s) might necessitate surgery in the future and how credit for this will need to be given

against any costs of future care presented in her claim. Clearly, then, this is a pleading point rather than one of expert evidence from Ms Campbell.

37. It is also clear from the Claimants' Dr Gardner-Thorpe that he too had been shown either one or both of Professor Mark's reports but the element of his incorporation into his own report is somewhat on, with respect, a "cut and paste" basis.

In his 12 September 2018 report, Dr Gardner-Thorpe does not list Professor Mark's reports in the paragraphs in his own report following the title "Medical Reports" and comments upon the MRI scan in terms similar to his 28 June 2018 letter. So he remarks at Page 7 :

"Now that a structural lesion has been demonstrated close to the spinal cord, further opinion is indicated. This would best be offered by an appropriate neurosurgeon. I have previously recommended the instructions of a neurosurgeon given the MRI findings and the number of potential causes of Miss Hall's right leg symptoms……."

However, only 4 lines later we read :

"I note the content of the report of Professor Marks (neurosurgeon). It is his view that there are no radiological findings which explain Miss Hall's right sided leg symptoms. I defer to him in relation to the neurosurgical aspects of this case"

38. The process by which the Claimant has achieved comment from her existing medical experts can be seen to be somewhat erratic and inconsistent at least in terms of final presentation. Be that as it may, on the basis that the exercise having been chosen and implemented unilaterally by the Claimant and then served upon the Defendant as if perfecting a previous direction of the court, I take the view I am entitled to proceed to consider these reports directly and assess the benefit of what response it has produced.

This is distinctly different from more abstract or hypothetical approach the Claimant adopted, for whatever reason, for most of the two hearings.

39. Dr Gardner-Thorpe as a neurologist may well defer to Professor Marks on matters of neurosurgery but this concession does not persuade me that there are neurosurgical aspects to the case.

Neither Mr McCloy nor Dr Harrison have been assisted by Professor Marks, neither can I follow how they might. The question, for example, of whether loss of core strength has increased the Claimant's weight and so exacerbated her symptoms (whether surgery related, constitutional or both) are quite capable of being considered by Mr McCloy, Dr Harrison and Dr Gardner-Thorpe.

Dr Turner does not rely upon Professor Marks for any discrete contribution from him but is instead quite capable of relying upon Dr Gardner-Thorpe's opinion that there is no organic cause for the right leg symptoms.

The deduction reflecting credit for any future unrelated operation to the tumour is quite capable of being subtracted from Ms Campbell's figures as they form part of the Claimant's Schedule of Loss. No dispute arises unless, as was the point I made in the hearing, the Defendant contends in reply for a longer period. As matters stand, Ms Campbell does not need to rely upon anything from Professor Marks to revise her own expert evidence.

40. This only leaves the evidential balance to be struck between Dr Gardner-Thorpe as a Part 35 neurologist in the case and his earlier clearly expressed desire to be further assisted by neurosurgical opinion. It seems to me this question ultimately has to be decided as a procedural question having regard to the court's duties to limit expert

evidence and the overriding objective, particularly in terms of limiting costs and reducing the number of issues. Permission to rely upon Professor Marks cannot be justified simply to satisfy clinical continuity and completeness.

The essential starting point is that it is now common ground in the claim that neither (i) the tumours or (ii) the right foot symptoms are a directly consequence of the index negligence. Dr Gardner-Thorpe had already clearly expressed reservations whether they ever were anyway. However, in simple objective terms there is now common ground and so the need for the formal introduction of expert comment by way of Part 35 permission is not needed to prove what is agreed.

As I have already stated, the incidence of the need to give credit for any surgery following a non-related condition does not of itself require expert evidence on the point.

Whilst I note that, in excluding the concerns that led to his instruction Professor Marks has offered in passing supportive comments about exacerbation of constitutional conditions or symptoms, this is ultimately neither a comment made in the context in which he was instructed nor one that adds anything to the litigation from the viewpoint of his particular discipline. Indeed, it seems opportunistic to now seek to rely upon it at all. Significantly, to return to the 28 June 2018 letter I was repeatedly referred to in the hearing by Mr Haines, Dr Gardner-Thorpe had never requested assistance from a neurosurgeon on this point. Neither has Dr Gardner-Thorpe suggested in his concluded report that he still does. More pertinently, Professor Marks in his first report comments how this point first appears from Dr Harrison. This is, in short, an attempt to use two experts to establish a point that has already sufficiently been made by one.

41. I am satisfied that there is no place for permitting neurosurgical expert evidence as a Part 35 discipline.

42. Subject to any submissions the Claimant may wish to make, it follows from this decision that :

42.1 The references to Professor Marks reports must be excised from the Claimant's current experts reports and those reports re-served, at the expense of the Claimant;

42.2 Extensions of time are appropriate to enable the Defendant to comply with the previous directions Order;

43.3 Any broader or more fundamental consequential directions to facilitate those previously ordered could arise and need to be considered;

43.4 The Claimant should pay the costs of and occasioned by her application as extends to two hearings, the second of which was quite unnecessary.

43. I would hope that the parties can explore the implications of this decision and agree an Order for approval without the need for another hearing. However, if a hearing is required, then the party needing it should apply to my clerk for a date to resume and conclude the Claimant's application as soon as possible.