



Neutral Citation Number: [2024] EWHC 3314 (KB)

Case No: KA-2023-000125

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
KINGS BENCH APPEALS

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 19/12/2024

Before :

MR JUSTICE SWEETING

Between :

ALAN PRESCOTT-BRANN

Appellant

- and -

**CHELSEA AND WESTMINSTERS HOSPITAL
NHS FOUNDATION TRUST**

Respondent (1)

SHIVA KOTEESWARAN

Respondent (2)

David Thomson (instructed by **POWELL AND COMPANY SOLICITORS LLP**) for the
APPELLANT

Anna Hughes (instructed by **WEIGHTMANS LLP**) for the **1ST RESPONDENT**
Claire Watson KC (instructed by **MEDICAL AND DENTAL DEFENCE UNION OF
SCOTLAND**) for the **2nd RESPONDENT**

Hearing dates: 24th June 2024

Approved Judgment

This judgment was handed down remotely at 10.30am on 19th December 2024 by circulation to the parties or their representatives by email and by release to the National Archives

MR JUSTICE SWEETING :

Introduction

1. This is an appeal against the order of Master Eastman, made on 25 May 2023, refusing the Appellant permission to rely on an alternative neurology expert. Permission to appeal was given by the single judge, Sir Stephen Stewart.
2. The Appellant, who was 36 years old at the time, attended West Middlesex Hospital on 25 June 2014, where a CT scan was performed. This scan was reported as normal by the Second Respondent, Dr Koteeswaran. The Appellant was subsequently discharged on 26 June 2014 with a diagnosis of migraine. On 27 June 2014, he suffered a further deterioration in his condition.
3. As then became clear, the Appellant had initially suffered from a thrombotic event as the result of an earlier dissection of his left vertebral artery. The Appellant alleges that there was a negligent delay in the diagnosis and treatment of his stroke, which caused or materially contributed to ongoing embolisation from the thrombus in the left vertebral artery and the worsening of his neurological injury. The Second Respondent has admitted a breach of duty in failing to identify and report the abnormal CT scan. The First Respondent, Chelsea and Westminster Hospital NHS Foundation Trust, has admitted that the Appellant should not have been discharged on 26 June 2014. Both Respondents deny that their admitted breaches of duty caused the Appellant's injury.
4. There is no issue that the Appellant suffered a tear/dissection in his left vertebral artery in his upper neck, which caused neck and head aches. The parties agree this caused thrombosis (a clot) to form in the wall of the left vertebral artery, which subsequently broke off and travelled to his left posterior inferior cerebellar artery (a thromboembolism). This thromboembolism caused poor blood flow to the area of the Cerebellum perfused by the artery, leading to an ischaemic episode/stroke at about 9 pm on 24 June 2014. However, the parties disagree as to whether he experienced further thromboembolic events in the days following his initial stroke, and whether earlier treatment would have made a difference to his outcome.
5. The Appellant's causative case is that had the stroke been Aspirin would have been prescribed on the morning of 25 June 2014 and he would have remained in hospital. Its anticoagulant effects would then have prevented a further thromboembolism within the left vertebral artery. Since the Respondents deny that there was any such second embolic event their case is that the administration of Aspirin would not have made a difference to the outcome. The claim therefore turns initially upon whether the Appellant has suffered damage through a second thromboembolism or simply as a result of the original infarction caused by the arterial dissection.

The Law – Appeals & Experts

6. The question for an appellate court when dealing with an appeal against a case management decision is whether the judge's decision was “wrong” (see *Walbrook Trustee (Jersey) Ltd v Fattal and Royal & Sun Alliance v T & N* [2009] EWCA Civ 297).
7. In *Global Torch Ltd v Apex Global Management Ltd* (No 2) [2014] UKSC 64 Lord Neuberger, in the Supreme Court, observed [13]: “Given that it was a case management decision, it would be inappropriate for an appellate court to reverse or otherwise

interfere with it, unless it was “plainly wrong in the sense of being outside the generous ambit where reasonable decision makers may disagree” as Lewison LJ expressed it in Broughton v Kop Football (Cayman) Ltd [2012] EWCA Civ 1743 , para 51.”

8. CPR 35.4 Provides that "No party may call an expert or put in evidence an expert's report without the court's permission." The parties in this case were permitted to call experts in the disciplines of neurology and neuroradiology. The court has a broad discretion to permit a party to rely on a second replacement expert in a permitted discipline. The usual rule is that the court should not refuse a party permission to rely on a new expert in substitution for an existing expert: *Edwards-Tubb v JD Wetherspoon plc* [2011] EWCA Civ 136 per Hughes LJ at [30]; *Murray v Devenish* [2017] EWCA Civ 1016 per Gross LJ at [15]-[16]. It is however a matter of discretion which is typically exercised on the condition that the report of the first expert is disclosed. The court should, as part of proper case management, discourage “expert shopping” and retains the power to impose additional terms for adducing further expert opinion evidence. The discretion to allow the substitution of an expert is exercised on a case-by-case basis, considering all of the relevant circumstances, which will include:
 - a. whether the proposed change is made too close to the trial date or may disrupt the proceedings and cause delays;
 - b. whether it is made solely to find an expert who will give a more favourable opinion (expert shopping);
 - c. whether the change would unfairly disadvantage the other party and;
 - d. whether a change would be contrary to the overriding objective of dealing with cases justly and expeditiously.

The Procedural Chronology

9. The Claim Form, along with supporting documents, was served on 16 July 2018. The parties agreed to a stay of proceedings from 16 July 2018, to 31 August 2020, to comply with the Pre-Action Protocol. On 31 May 2019, the Respondents submitted their Letters of Response. The Appellant sought an extension for filing the Particulars of Claim on 30 August 2019. The Particulars of Claim, along with supporting documents, were served on 6 February 2020. Defences were served by both Respondents on 5 February 2020.
10. The first Case Management Conference was held on 1 February 2021, before Master Eastman. The Appellant sought permission to rely on a second neuroradiology expert, Dr. Birchall, due to a change in opinion from his initial expert, Dr. Nelson. Permission was granted, conditional on the disclosure of all reports from Dr. Nelson. Unsupportive reports from Dr. Nelson were disclosed on 11 February 2021. Disclosure by list took place in April 2021. The Appellant served witness evidence on 13 July 2021.
11. The trial was scheduled to commence on 21 November 2022. On 5 November 2021, the Appellant indicated that he was unable to exchange expert evidence and intended to amend the Particulars of Claim. On 25 November 2021, the Appellant formally applied for permission to amend the Particulars of Claim and rely on evidence from a stroke expert. The Appellant applied to vacate the trial on 19 July 2022. The trial was vacated on 19 August 2022, with the Appellant ordered to bear the costs occasioned by the breaking of the fixture.
12. Another hearing took place before Master Eastman on 10 February 2023. The Appellant's application to rely on a stroke expert, Dr. Starke, was refused. The Appellant then sought permission to replace his neurology expert, Professor Wills, with

Approved Judgment

a new expert. On 16 February 2023, the Appellant disclosed correspondence with Professor Wills. On 17 February 2023, the Appellant identified Dr. Arvind Chandratheva as his proposed, new, neurology expert.

Master Eastman's Decision

13. The application came before Master Eastman on 25 May 2023 when he gave an extempore judgment, refusing the Appellant's application to rely upon the opinion of Dr. Chandratheva instead of Professor Wills. A transcript of the judgment was later approved.
14. The Master refused permission for the Appellant to rely on Dr Chandratheva's evidence for the following reasons:
 - a. The application was made "very, very late indeed".
 - b. Professor Wills had not changed his opinion but had maintained his view throughout that prescribing anticoagulation therapy (Aspirin) by 2:00 p.m. on 25 June 2014 would not have changed the outcome.
 - c. The application had the "aroma of a late attempt at expert shopping".
 - d. He was "not satisfied that Dr Chandratheva's report helps the Appellant's case in any great way."
 - e. Dr Chandratheva had been provided with an inappropriate list of documents, which was "partial and inappropriate" and included the report of an expert whom the Appellant was not permitted to rely on.

Grounds of Appeal

15. The grounds of appeal are as follows:
 - a. Ground 1: The Master was wrong to find that Professor Wills was consistently unresponsive of the Appellant's case.
 - b. Ground 2: The Master erred in law by failing to take account of the fact that Professor Wills failed to consider the expert evidence from Dr Birchall.
 - c. Ground 3: The Master was wrong to decide that Dr Chandratheva's opinion was not supportive of the claim.
 - d. Ground 4: The Master was wrong to decide that Dr Chandratheva's report did not help the Appellant's case.
 - e. Ground 5: The Master was wrong as he failed to take account of the fact that Dr Chandratheva had considered the opinion of Dr Birchall.

Expert Evidence

16. Neurology expert evidence is central to the issue of causation in this case and is directed towards:
 - a. The Appellant's neurological presentation over time;
 - b. The available treatments; and
 - c. The likely outcome had medication been administered.
17. The Appellant initially instructed Professor Wills as his neurology expert. Professor Wills provided three reports dated:

Approved Judgment

- a. 15 December 2017
 - b. 8 November 2019
 - c. 25 November 2019.
18. He also commented on a draft of the Particulars of Claim in January 2020.

Professor Wills' Opinions

19. In his first report, Professor Wills expressed the opinion that Aspirin would not have made any difference to the outcome as he believed that the Appellant's stroke was already established by the time he attended hospital.
20. In his second report, Professor Wills indicated that his opinion was necessarily fact sensitive. He suggested that if the Appellant's account of his symptoms was correct then he may have suffered a "stroke in evolution". If so, then earlier administration of Aspirin may have made a difference to the outcome. However, he expressed the view that if Dr Kennedy's account was accurate then the stroke was complete upon presentation.
21. Dr. Kennedy was a consultant neurologist at the Cromwell Hospital. He examined the Appellant during his attendance at the Cromwell Hospital and found him to be unsteady, with evidence of left Horner's syndrome and clumsiness of the left arm. Dr. Kennedy also noted some spinothalamic sensory loss. The Appellant had told Dr. Kennedy that he had experienced clumsiness in his left arm while at West Middlesex Hospital, but that the significance of this was not appreciated by doctors there. However, the Appellant later acknowledged that the account he gave to Dr. Kennedy was inaccurate, as he had given the impression that all of his symptoms were present during his time at West Middlesex Hospital, when they had in fact developed over time.
22. In his third report, Professor Wills reiterated the view that earlier treatment would not have altered the Appellant's outcome unless he was suffering from a stroke in evolution.
23. The Appellant contends that Professor Wills subsequently changed his opinion, stating that the deterioration in the Appellant's condition was likely due to increased brain swelling, as identified by the Appellant's neuroradiology expert, Dr Nelson. The Appellant sought to rely on an alternative neuroradiology expert, Dr Birchall.
24. Dr. Birchall, a consultant neuroradiologist, provided an expert report for the Appellant. In preparing his report, he reviewed the imaging from West Middlesex Hospital and the Cromwell Hospital. Dr. Birchall agreed with Dr. Nelson's revised opinion that the swelling in the ischaemic area of the cerebellum had increased from mild to mild/moderate from 25 June 2014 to 27 June 2014. However, Dr. Birchall concluded that the swelling was not compressing adjacent brain structures, such as the medulla oblongata. He also observed a separate area of ischaemic damage to the left side of the medulla oblongata, in addition to the area of damage in the cerebellum. Dr. Birchall believed this damage to the medulla oblongata was likely caused by thrombo-emboli from the left vertebral artery. He stated that the swelling in the cerebellum was not sufficient to cause compression of the medulla oblongata and was therefore unlikely to be the cause of the damage. Dr. Birchall's opinion was that the imaging, considered in its factual context, indicated that there was an increase in swelling of the ischaemic cerebellar tissue, but that the medulla oblongata damage was vascular in nature.
25. Dr. Birchall acknowledged that it was not possible to determine from the radiological imaging whether the medullary and cerebellar infarcts occurred at the same time or not. In his judgment, Master Eastman misattributed this opinion to Dr. Chandratheva.
26. Professor Wills, it is said, refused to consider Dr Birchall's report. As a result. The

Approved Judgment

Appellant sought permission to instruct Dr Chandratheva, a consultant neurologist and stroke physician.

Dr Chandratheva's Report

27. Dr Chandratheva is a consultant neurologist and stroke physician. He provided an expert report for the Appellant, dated 3 April 2023.
28. Dr Chandratheva agreed with Dr Birchall's assessment that there was progression of swelling of the cerebellar tissue from the first scan on 25 June 2014 to the later scans on 26 and 27 June 2014. However, he also agrees with Dr Birchall that the swelling did not cause compression of the medulla oblongata and that the damage to the medulla oblongata was caused by thrombotic occlusion of the medullary blood supply from branches of the left vertebral artery close to the origin of the left posterior inferior cerebellar artery. Dr Chandratheva considered that the moderate degree of swelling of the cerebellar area was unlikely to affect the medulla oblongata.
29. He noted that it was difficult to assess the Appellant's case, because of the lack of like-for-like scans for comparison. This is because the cerebellar ischaemia was not identified on the CT scan performed on 25 June 2014. He also accepted that the imaging alone cannot determine whether the damage to the different areas occurred at the same time or not. He noted Dr Birchall's explanation that this is due to the short time span between the events and the fact that only a plain CT scan was performed on 25 June 2014.
30. Based on the wider evidence and Appellant's clinical records, his opinion is that the cerebellar infarct likely occurred first, on 24 June 2014, followed by the medulla oblongata infarct on 27 June 2014. While he acknowledges that he cannot be certain whether there was an evolving stroke and secondary oedema or further recurrent embolic events, he considers further embolic events probable. He concludes that if the Appellant had received 300mg of Aspirin on the morning of 25 June 2014, further thrombo-emboli from the left vertebral artery would probably have been stopped within 24-48 hours. This would not have prevented any existing stroke changes and oedema, but would have prevented subsequent thrombo-emboli from the left vertebral artery thrombus and recurrent stroke risk due to emboli. Thus his overall conclusion is that the Appellant's deterioration was caused by further thrombo-emboli, and that the administration of Aspirin on the morning of 25 June 2014 would have prevented this deterioration.

Discussion and Conclusions

31. Professor Wills' initial report was prepared without the benefit of a full statement from the Appellant and without seeing him. In his second report, Professor Wills acknowledged that if the Appellant's account of his symptoms was correct, then this suggested a "stroke in evolution". If it was indeed a stroke in evolution, then earlier treatment would have made a difference. Professor Wills did not maintain that earlier treatment would not have made a difference in his second and third reports. Rather, he stated that earlier treatment would not have made a difference unless the Appellant was experiencing a stroke in evolution. He was not therefore consistently unsupportive of the Appellant's case. The Master referred to and quoted from the first unsupportive

report in the course of his judgment but it was not correct to say that Professor Wills initial view had been maintained throughout. It had been made subject to a caveat dependent upon factual findings.

32. That may raise a question as to whether it was necessary to seek to substitute another expert for Professor Wills. However, the Appellant's solicitor has provided, what is in effect, unchallenged evidence that Professor Wills has not been prepared to fully engage with the report of the Appellant's new neuroradiology expert, Dr Birchall. There is some evidence in the e-mail correspondence that Professor Wills had become frustrated with the process in which he was being asked to engage but I accept for present purposes that the Appellant's legal advisors have raised a legitimate concern. Professor Wills is an eminent clinician and I should make it clear that I am not, in this judgment, expressing any view about the performance of his duties as an expert witness. It is a feature of complex litigation in this area that from time to time parties lose confidence in the experts they have instructed. Where that loss of confidence has a foundation beyond mere assertion and where there is a good apparent reason for a change of expert, then subject to the principles set out above it is rarely productive for there to be satellite litigation drawing in the experts themselves.
33. Contrary to the conclusion reached by the Master, Dr. Chandratheva's report does support the Appellant's case. Dr. Chandratheva's opinion was that further embolic events were the probable cause of Mr. Prescott-Brann's neurological decline. He formed this opinion based on the contemporaneous hospital records and the Appellant's symptoms and signs, which he concluded indicated that the cerebellar infarct occurred first and the medullary infarct occurred second. The Master misattributed an observation from the radiologist's report (Dr Birchall) to Dr Chandratheva in the course of his judgment and on the basis of this misattribution concluded: *"In other words, he cannot tell whether the problems that the claimant is left with now, when looking at the radiology, are as a result of it all happening in one go at the beginning, so to speak, or as the claimant would have it, evolving in a way in which aspirin might have helped"*. For the reasons set out above this mischaracterised the effect of Dr. Chandratheva's evidence.
34. Having regard to all the circumstances, I am satisfied that the Appellant has demonstrated a good reason to change experts. The application is not so late as to be prejudicial to the Respondents, and I do not consider that the Appellant is engaging in expert shopping. I am not persuaded that the provision of Dr Starke's report to Dr Chandratheva is a significant factor. Dr Chandratheva's report clearly demonstrates that he has reached his own independent conclusions based on the evidence.
35. In all the circumstances, I am satisfied that the Appellant should be granted permission to rely on the expert evidence of Dr Chandratheva in substitution for Professor Wills.
36. The appeal is therefore allowed. The parties should file an agreed draft order giving effect to this judgment, providing for costs and including any further directions as to the progress of the litigation that the court is invited to make consequent upon the judgment. In relation to any matter which is not agreed the parties should file short written submissions as to the form of the order within seven working days of the judgment being handed down.

END