Neutral Citation Number: [2021] EWHC 2795 (QB)

Case Nos: QB-2020-002743

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 26/10/2021

Before:

MR CLIVE SHELDON QC
SITTING AS A DEPUTY JUDGE OF THE HIGH COURT

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Between:

MARK DUFFIELD	**Claimant**
– and –	
METAMORPH LAW LIMITED	**Defendant**

- -
- -

John Stevenson (instructed by **Hodge Jones & Allen**) for the **Claimant**
Jamie Carpenter QC (instructed by **Travelers Legal**) for the **Defendant**

Hearing dates: 6 – 7 October 2021

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Approved Judgment

Clive Sheldon QC, sitting as a Deputy Judge of the High Court:

1. The Claimant, Mark Duffield, has brought a claim against the Defendant law firm, Metamorph Law Limited ("Metamorph"), for professional negligence. The claim, which is brought in both contract and tort, arises out of the way in which Metamorph and the predecessor firm of solicitors to Metamorph, Linder Myers LLP, handled a claim for clinical negligence arising out of Mr. Duffield's medical treatment, in particular the prescription in 2001 of *Rifinah*, a drug used in the treatment of tuberculosis. Mr. Duffield believed that the drug was responsible for him developing two conditions: Primary Biliary Cirrhosis (PBC) and Postural Orthostatic Tachycardia Syndrome (POTS).

2. Proceedings were issued by Mr. Duffield against Metamorph on August 5th 2020. The claim form stated that "The Claimant claims for damages for breach of duty in contract and tor[t] arising out of the Defendant's failure to investigate and pursue a personal injury claim against the clinicians responsible for the Claimant's medical treatment in about 2001". The Particulars of Claim allege 12 particulars of negligence against the Defendant.

3. On April 12th 2021, the Defendant made an application for summary judgment and to strike out the Particulars of Claim. On June 21st 2021, the Claimant made an application for summary judgment in respect of the claim, with damages to be assessed. On October 6th-7th 2021, I heard oral argument on both applications.

I. Factual Background

4. It is not necessary for me to set out the factual background to Mr. Duffield's treatment in great detail, as this only provides the context to the claim for professional negligence. I will set out, in more detail, the factual background to the way in which Mr. Duffield's clinical negligence claim was investigated and handled.

(i) Medical Treatment

5. In July 2001, Mr. Duffield was exposed to a risk of infection with tuberculosis. Liver Function Tests (LFTs) were carried out on September 6th 2001, and these showed mild elevation of Alanine Aminotransferase and Gamma-GT. On September 19th 2001, Mr. Duffield was seen at the TB Clinic at Manor Hospital, Walsall by Dr. Yugambaranathan (in some of the subsequent correspondence, the doctor is referred to as "Dr. Yugam"). Mr. Duffield was offered chemoprophylaxis in the form of *Rifinah 600mg* daily for three months. *Rifinah* contains the drugs rifampicin and isoniazid. Dr. Yugambaranathan had not been made aware of Mr. Duffield's LFT results and so did not advise him how this affected the risks of treatment with *Rifinah.*

6. Later on September 19th 2001, Dr. Yugambaranathan wrote to Mr. Duffield's GP, Dr. Gandhi, stating that

> "we have decided to give him chemo-prophylaxis in the form of Rifinah 600mg daily for 3 months. I have explained the side effects profile . . . I have also advised him that if he should develop these symptoms he should contact either the TB Clinic or yourself. I have today given him a prescription for Rifinah 600mg 2 daily for 1 month."

The latter sentence was an error. Dr. Yugambaranathan had not, in fact, prescribed that amount of *Rifinah.*

7. On October 5th 2001, Mr. Duffield received a further prescription for *Rifinah*. The prescription was for "300mg 4 daily". This amounted to 1200mg of *Rifinah*, twice the dose of the drug that should have been prescribed to Mr. Duffield. This prescription was issued by Dr. Gandhi, and not Dr. Yugambaranathan. Mr. Duffield has also said that he was issued with a further prescription by Dr. Gandhi 28 days later. There is, however, no documentary evidence available for this further prescription.

8. Mr. Duffield alleges that he felt increasingly ill after taking the *Rifinah*, and went back to the TB Clinic. Mr. Duffield was advised to stop using the *Rifinah*. In early 2002, Mr. Duffield tested positive for anti-mitochondrial antibodies (AMA), but says that he was not told of this at the time. Mr. Duffield was discharged from the TB clinic on July 10th 2002.

9. Mr. Duffield has developed both PBC and POTS. He attributes these to the prescription and/or over-prescription of *Rifinah*.

(ii) <u>The Investigation and Handling of Mr. Duffield's Legal Claim</u>

10. In December 2011, Mr. Duffield instructed Linder Myers LLP to investigate a claim arising out of an alleged failure to inform him of the positive AMA in 2002, and to investigate a claim arising out of the failure to identify abnormal LFTs before he was prescribed *Rifinah* in 2001. Mr. Duffield had learned of these matters on reading his GP records in the summer of 2011. The solicitor at Linder Myers LLP who had day-to-day responsibility for Mr. Duffield's claim was Siôn Wynne, a partner at the firm who specialized in conducting medical negligence claims on behalf of claimants.

11. The investigation of the claim was initially funded by Legal Aid. In June 2012 Mr. Duffield obtained further medical notes from his GP. On reading his notes, Mr. Duffield discovered that he had been prescribed an overdose of *Rifinah*, and he discussed this with Mr. Wynne by telephone on June 19th 2012. In his witness statement prepared for the present applications, Mr. Duffield alleges that he informed Mr. Wynne that the overdose had been prescribed by his GP, Dr. Gandhi. Mr. Duffield also asserts that he had "never at any point thought the overdose was issued by the hospital pharmacy. . . I have never told Mr Wynne that I thought that the hospital issued the overdose." Mr. Duffield also says that, on June 21st 2012, he attended his GP surgery and they printed out for him a copy of his GP prescription list. Mr. Duffield says that this "clearly showed that the overdose of Rifinah was issued by the GP". Mr. Duffield says that he sent this printout to Mr. Wynne either on the same day or shortly afterwards.

12. Mr. Wynne disputes this version of events. In a witness statement prepared for these applications, Mr. Wynne says that he assumed that the overdose of *Rifinah* had been prescribed by Dr. Yugambaranathan and was not told otherwise by Mr. Duffield until much later. In this regard, Mr. Wynne has exhibited hand-written notes of his telephone conversation with Mr. Duffield on June 19th 2012, in which there is no mention that the GP prescribed the overdose. Mr. Wynne has also exhibited a letter from Mr. Duffield dated June 27th 2012, which enclosed two versions of Dr. Yugambaranathan's letter of September 19th 2001: one with the annotation "given Rifinah 300mg 4 daily (112) on 5-10-01", and one without the annotation. In his letter of June 27th 2012, Mr. Duffield stated

> "As you can see I was given twice the highest dosage of Rifinah 1200 mg per day. Looking at both letters you can clear see Dr Yugam has altered this letter and signed it. And dated it. This date the 5/10/01 was my two week blood test result when I visited Dr Yugam. He should have stopped Rifinah lowered the dose and informed me . . . But instead of this he doubled an already dangerous drug to 1200 mg per day and he stated he gave me this prescription."

13. In his letter of June 27th 2012, Mr. Duffield also said that his GP "has a copy of 4 x 300 mg per day Rifinah in his prescription lists." Mr. Duffield did not say that this was a list of prescriptions issued by his GP. In an accompanying document, Mr. Duffield stated that the letter of September 19th 2001 was "held back from being sent to my GP until 5/10/01, the day I received my two week test results… At some point before being sent to the GP the original typed letter was altered by pen". This implied that the over-prescription – and the annotation – were made by Dr. Yugambaranathan, or someone at the hospital.

14. Mr. Wynne met with Mr. Duffield on October 12th 2012 to discuss the case and to take a witness statement from him. In Mr. Wynne's witness statement, he says that he believed that it was at this meeting that Mr. Duffield may have provided him with a copy of the prescription print-out from his GP. Mr. Wynne says that

> "Whenever it was provided, I have no recollection of discussing its content or receiving any explanation of what the printout showed. Mr Duffield certainly never informed me that the document was a list of prescriptions that had actually been issued by his GP. . . I believe that I thought it was just a list of medication that Mr Duffield had received from all sources, not just from his GP." Mr. Wynne also says that during the course of their meeting, Mr. Duffield "made no mention to me that it was the GP who issued the overdose prescription or that his GP was involved in determining the dosage required".

15. On October 23rd 2012, Mr. Wynne sent to Mr. Duffield a draft witness statement. Mr. Duffield was asked to read the draft and check for any factual errors. Mr. Wynne also stated that he was returning the prescription information from the GP records that Mr. Duffield had given him when they met. The draft witness statement, which Mr. Duffield signed and dated on December 13th 2012, included the following:

> "I think it was after the appointment on the 19th September 2001 which is noted in my medical records that I was started on the two week test dose of Rifinah having been told my blood tests showed my liver function was normal. I then went back to the hospital on the 5th October 2001 when I was prescribed the first month's worth of the three month course of the drug having again been told that the check blood tests were normal."

The clear implication is that the prescription issued on 5th October 2001 was from Dr. Yugambaranathan and not the GP.

16. Mr. Duffield issued a complaint about his treatment by the hospital. On October 26th 2012, Mr. Duffield met with Dr. Yugambaranathan, and others from Manor Hospital,

Walsall to discuss his treatment. From a file note of that meeting, it can be seen that Mr. Duffield stated that a mistake had been made in the dosage of *Rifinah* that he had been prescribed: "he took twice the maximum dose over a period of seven weeks." Notes of the meeting state that "Dr Yugambaranathan noted that in his health records Mr Duffield was instructed to take 300mg twice daily. Mr Duffield responded that he was instructed to take 300g four times daily and he did so until he collapsed." Mr. Duffield stated that "he took two doses of two tablets a day and he confirmed this with his GP" and the notes say that "Mr Duffield showed the assembled group the fax of Dr Yugambaranathan's letter to his GP". Mr. Duffield was asked which pharmacy he had visited and said that he could not remember.

17. In March 2013, following the issuance of a Notice to Show Cause letter from the Legal Services Commission, Mr. Wynne advised Mr. Duffield to switch funding to a Conditional Fee Agreement (CFA) and After the Event (ATE) insurance. Mr. Duffield entered into a CFA with Linder Myers LLP on March 15th 2013. An express term of the CFA was that the firm could terminate the agreement if they believed that Mr. Duffield was unlikely to win his claim.

18. On March 28th 2013, an ATE policy was issued by an insurer, Temple Legal Protection Ltd. ("Temple"), pursuant to delegated authority held by Linder Myers LLP. This required Mr. Duffield's claim to have at least 51% prospects of success at trial. The ATE policy provided that:

> **"4. Instructions to the Appointed Legal Representative**
>
> The Insured gives irrevocable instructions to the Appointed Legal Representative to:
>
> a) provide Temple with such information, documentation or particulars, whether privileged or not, relating to the Legal Action as it may require;
>
> b) notify Temple of any fact or matter adversely affecting the prospects of a successful outcome for the Insured . . . "

The ATE policy also provided that:

> "**Termination**
>
> . . . If there is any material deterioration in the prospects of a successful outcome at trial for the Insured . . . Temple may terminate this Certificate immediately."

19. In his witness statement, Mr. Wynne describes Temple's approach to the prospects of success. He says that the requirement that claims have at least 51% prospects of succeeding at trial continues throughout the lifetime of the claim, and that any developments or events which were considered to reduce the prospects below this level had to be reported to Temple. Mr. Wynne explains that:

> "Withdrawal of the ATE cover would be the inevitable consequence in this situation. Any advice from Counsel would be an essential part of this process. Unless there were any substantial reasons not to do so,

> Temple would obviously place great reliance on Counsel's advice in a case, which would be treated as authoritative and effectively a conclusive assessment of merits and prospects."

Mr. Wynne also explains his firm's criteria for entering into a CFA: that this had to be assessed as having at least 51% prospects of succeeding at trial.

20. A number of experts were contacted by Mr. Wynne, and also by Mr. Duffield, to see if they could assist in establishing a causative link between the taking of *Rifinah* and Mr. Duffield's PBC and POTS. One of the experts, Professor Walley (referred to in some of the documents as "Professor Whalley") – a Clinical Pharmacologist and Consultant Physician – was provided with Mr. Duffield's medical records, as well as complaints correspondence and the witness statement of Mr. Duffield that had been prepared by Mr. Wynne. In the instructions to Professor Walley, Mr. Wynne wrote that Mr. Duffield had been given a prescription for 600mg of *Rifinah* twice daily, and in reference to the letter of September 19th 2012 he stated that "Interestingly the latter has a handwritten note confirming 300mg four daily it is thought written by the hospital doctor at Mr Duffield's review appointment following the two week test dosage on 15th October 2001)." This instruction evidences Mr. Wynne's then understanding that the over-prescription of *Rifinah* was issued by Dr. Yugambaranathan.

21. On November 18th 2013, in a cover letter to his report, Professor Walley set out his key conclusions. He stated that it "was reasonable to prescribe Rifinah to Mr Duffield in 2001"; and that the PBC "may have been present before he received the Rifinah (as evidenced by the abnormal liver function tests before drug therapy)". In any event, Professor Walley said that he had "been unable to confirm any association between Rifampicin or Isoniazid and [PBC]"; similarly, he had "been unable to find a relationship with the development of POTS and Isoniazid". Professor Walley also stated that Mr. Duffield "was misprescribed an excessively high dose of Rifinah, due to an error in the letter signed by Dr Yugam, leading the GP to issue a prescription for an excessively high dose. This is clearly Dr Yugam's fault".

22. In his expert report, Professor Walley expressed the view that the annotation on Dr. Yugambaranathan's letter of September 19th 2001 was "I believe by the GP (see GP prescribing records, section 9, which record this)." Professor Walley commented that his interpretation of what had happened was that:

> "Dr Yugam initially issued a prescription for Rifinah for a test period of 300/150 two per day for two weeks: however, when Mr Duffield returned at the end of the two weeks, a further prescription was written but not by Dr Yugam but now by Mr Duffield's GP who, not being familiar with Rifinah, based his prescription on the letter on file which specifically stated the dose at 600 mg twice per day.
>
> I suspect this is a transcription error on the part of Dr Yugam's Secretary, but Dr Yugam failed to spot the error and must take responsibility for it. The result was that from 05 October 2001 onward Mr Duffield was given Rifinah 300 mg four times a day in error."

It is clear, therefore, that it was Professor Walley's reading of the records that the over-prescription of *Rifinah* was issued by the GP.

23. In his witness statement, Mr. Wynne says that he is uncertain how Professor Walley came to the conclusion that the GP had prescribed Mr. Duffield the overdose. He also says that "I cannot recall picking up on Professor Walley's comment at the time, maybe due to the more problematic issue of causation": that is, that there was no link between *Rifinah* and developing PBC. (I note in passing that there is a further document exhibited to Mr. Duffield's witness statement which appears to be a note of a telephone conversation between Mr. Wynne and Mr. Duffield on or around April 17th 2013. The note reads "p/o [presumably print-out] prescription from GP" and then refers to "Rifinah" and different dosages of the drug. This note was not explained in the witness evidence, and was not referred to in oral argument by either counsel, although in his skeleton argument Mr. John Stevenson, counsel for the Claimant, refers to this document among his reasons for contending that the file shows that Mr. Wynne must have known (or ought to have known) that the overdose prescription was issued by the GP).

24. On July 21st 2014, Mr. Wynne wrote to Mr. Duffield to explain to him about the statutory limitation period for his clinical negligence claim. Mr. Wynne stated that a claim for damages for personal injury and losses as a result of negligence had to be brought within 3 years of the original incident or sometimes later if the injury or its cause was not immediately apparent. Mr. Wynne pointed out that Mr. Duffield had been prescribed *Rifinah* more than 3 years ago, and so he would have to rely upon not having gained the requisite knowledge until much later, referring him to section 14A of the Limitation Act 1980. Mr. Wynne said that it was very difficult to determine when Mr. Duffield had gained requisite knowledge for the purposes of limitation. Mr. Wynne went on to say:

> "On reviewing my file of correspondence I note that you telephoned me on the 7th September 2011 to advise you had reviewed your GP records and discovered that your liver function tests were abnormal before you were prescribed Rifinah and there was a positive AMA test in 2002. It was on this basis that we applied for Legal Aid on your behalf in December 2011. It was not until the 19th June 2012 that you telephoned me to advise your further consideration of the GP notes revealed you had been prescribed an overdose of Rifinah. Thereafter it appears you first suspected you suffered with POTS around November/December 2012 and it was in December 2012 that you were referred to Professor Gammage.
>
> I note you were advised you had been diagnosed as suffering with PBC at a consultation with Dr Awasthi on 10th August 2011. This is why we had been taking the 9th August 2014 as the earliest for expiry of the limitation period. I am uncertain as to when you were advised the PBC may have been caused by your prescription with Rifinah and/or when you obtained copies of your GP notes and discovered the matters you discussed with me on the 7th September 2011.
>
> If it is ultimately only the excessive dosage of Rifinah that forms a basis for a claim then it maybe argued that you did not have knowledge that you had been prescribed an overdose until June 2012, such that limitation would not expire until June next year. Further if the injury pursued is your suffering with POTS and not PBC then your date of knowledge and expiry of limitation would be even later.

> However, it would seem limitation in respect of any claim arising out of your being prescribed Rifinah in the first place and this having caused PBC may arguably expire sometime during August or September this year".

25. Mr. Wynne also explained that they did not have evidence to support the claim at that point in time:

> As we have discussed on the basis of the available expert evidence from Professor Walley I do not consider you would be justified in commencing legal proceedings at this stage or that this was an expense your After the Event insurers would accept it was reasonable to incur."

26. Mr. Duffield met with Mr. Wynne on December 4th 2014. From a file note of that date, it can be seen that Mr. Wynne pointed out that "The big problem [with Mr. Duffield's case] is that there is no single published [report] which confirms a link between Rifinah and its two component drugs causing PBC. To do so would be an advance in medical science", and that he did not think "it is yet proven that [the] prescription of Rifinah was negligent." Furthermore, Mr. Wynne commented that even if a link could be established between the prescription of *Rifinah* and PBC, it was "highly unlikely" that they would be able to prove that the additional dosage was responsible for his PBC. Mr. Wynne explained that he was "pessimistic" about proving causation to a legal standard required to succeed in a claim at court.

27. Further materials were then provided to Professor Walley, who wrote back to Mr. Wynne on December 23rd 2014 to say that "I think Mr Duffield MAY have suffered a rare and previously undescribed adverse reaction: but that the balance of probability is against it. I am obviously most swayed in this by the depth and length of experience with rifampicin and isoniazid". This was a reference to the fact that those drugs had been prescribed to very large numbers of people over many years, and no connection with PBC had been reported. Professor Walley concluded his letter by saying that "If this case is to continue, you need to find a hepatologist who is prepared to stand up in court and say that Mr Duffield's PBC is most likely drug related, and a neurologist who is prepared to stand up in court and say that Mr Duffield's POTS is most likely drug related."

28. On January 14th 2015, Mr. Duffield emailed Mr. Wynne to say that "one point I forgot to mention putting aside pots and pbc the hospital are neglig[e]nt for giving me an overprescription of rifinah causing me serious injury and illness." Mr. Duffield was still saying, therefore, that it was the hospital and not his GP who had over-prescribed the *Rifinah*.

29. Through his own research, Mr. Duffield identified a hepatologist, Professor Moore, who he thought might be able to assist with his case. Professor Moore was contacted by Mr. Wynne. In his witness statement, Mr. Duffield comments that the Defendant did not try and progress his case, and it was only because of his own research that they were able to find suitable experts to support his case. He expresses the belief that "it is totally unacceptable that the instructed solicitors failed to find suitable experts which resulted in years of wasted time, when I as a client managed to find two suitable experts [Professors Moore and Branley] within a couple of weeks." Professor Branley was a respiratory expert.

30. On February 10th 2015, Linder Myers LLP issued a claim form on Mr. Duffield's behalf against Walsall Healthcare NHS Trust ("the Trust"), the authority responsible for Manor Hospital, Walsall. The brief details of the claim were stated to be "Damages for personal injuries and losses suffered as a result of alleged clinical negligence suffered relating to medical care and treatment the Claimant received at Walsal[l] Manor Hospital between September 2001 and July 2002." This would cover the period of the initial prescription and over-prescription of the *Rifinah*.

31. The rationale for issuing "protective legal proceedings" was explained by Mr. Wynne in an email to Mr. Duffield dated February 4th 2015, and a subsequent letter dated February 9th 2015. Mr. Wynne explained that "positive feedback" had been received from Professor Moore as to the potential link between the prescription of *Rifinah* and his developing PBC.

32. Mr. Wynne also explained that the Trust would be likely to raise a point on limitation, arguing that Mr. Duffield was diagnosed with PBC in August 2011 and he was aware by September 2011 that the liver function test had been abnormal prior to the prescription of *Rifinah* in 2001 and that there had been positive AMA test results in 2002. As a result, limitation would arguably have expired in September 2014. However, Mr. Wynne pointed out that the Court has discretion to extend time (per section 33 of the Limitation Act 1980), and the Trust had not suffered any prejudice in the 4 to 5 month delay in proceedings being issued, as the Trust had been aware of the matter since 2011 and had undertaking a detailed investigation of a complaint made by Mr. Duffield.

33. On February 12th 2015, Mr. Duffield emailed Mr. Wynne to say that with respect to the question of limitation "we now know all my problems (pbc and pots) were likely due to excessive dose rifinah and associated liver injury and that limitation is not up for this until June this year, which means we have not missed it." In a subsequent email, Mr. Duffield said that "what i meant was i did not discover i had been overdosed on rifinah until June 2012 and this is when I informed you of the overdose. . . . Therefore it will not be three years until june this year."

34. Professor Branley issued a report in October 2015. Mr. Wynne says in his witness statement that it was following receipt of this report that Mr. Duffield told him that the overdose of the drug had been prescribed by the GP and not the hospital. This is reflected in a file note of a meeting between Mr. Duffield and Mr. Wynne held on October 12th 2015, which reads:

> "You say that Dr Yugam asked you whether you wished to receive the drugs from the TB clinic or via your GP. You chose your GP. You say you clearly remember collecting your prescription for the Rifinah from the GP on two occasions and taking it to the local pharmacy where it is dispensed. [Mr. Wynne] queries why when he repeatedly asked you about where the prescriptions were received from and that the drugs dispensed days ago and then you said you could not remember at all but now you have such a clear memory."

This is the first time in the documents that we see an express reference to Mr. Duffield saying that the prescription (and by implication the over-prescription) had been obtained from his GP. In an email dated October 13th 2015, Mr. Duffield wrote that "i am certain i got the prescription from my gp through the chemist".

35. In a subsequent report, Professor Branley advised that Mr. Duffield should have been told about the abnormal pre-treatment LFTs to enable him to make an informed choice about his treatment. In addition, he advised that Mr. Duffield had been prescribed double the normal dose of *Rifinah* for at least one month and that this had led him to develop hepatoxicity.

36. On November 3rd 2015, the GP surgery confirmed that the computerised record which had been provided to Mr. Duffield (and which had previously been shared with Mr. Wynne) was the list of medication prescribed by the surgery; that a doctor at the practice did prescribe *Rifinah* 300mg/150mg 112 tablets to be taken 4 daily on 5th October 2001; and that Dr. Gandhi was the GP who had issued the prescription. Furthermore, the GP surgery explained that the annotated note to Dr. Yugambaranathan's letter of September 19th 2001 was generated by the surgery's prescription department. The note had been written onto the letter from Dr. Yugambaranathan "for the sole reason of highlighting that the requested medication (600mg 2 daily) was not available hence doubling the dose to 300mg 4 daily." In subsequent correspondence, the GP surgery stated that they had searched all of their records, and made contact with the chemist and the prescription pricing authority, but could not verify that a further prescription for *Rifinah* was issued to Mr. Duffield on November 2nd 2001.

37. In March 2016, Dr. Hayat, a Consultant Cardiologist and Electrophysiologist was instructed to advise on the connection between *Rifinah* and POTS. He had been identified through the charity POTS-UK. In a report sent in June 2016, Dr. Hayat expressed the view that a possible trigger for Mr. Duffield's POTS was the overdose of isoniazid (one of the drugs in *Rifinah*).

38. Mr. Wynne instructed counsel, Dr. Jonathan Punt, to advise in conference on July 21st 2016. Dr. Punt was asked to consider the issues of breach of duty and causation with Mr. Duffield's medical experts, and to assess the merits of the claim. At that time, Particulars of Claim had not been served and various extensions of time for service had been granted by the Court. The instructions to Dr. Punt included many documents, including various expert reports and Mr. Duffield's medical records.

39. Dr. Punt was a former Consultant Neurosurgeon who had been called to the Bar in 2005. At the time of his instruction, he was rated as a leading junior in the area of clinical negligence in the *Chambers & Partners* directory. Dr. Punt accepted instructions on the basis of a CFA, even though he explained to his clerk that "my current assessment of prospects is below 50%". He asked his clerk to inform Mr. Wynne that:

> "This is a very complex case in which there is expert evidence that may link the administration of a drug to the development of one, or possibly two, conditions that may themselves be causally linked. There are competing non-negligent causes. The position as to breach of duty is also difficult, notwithstanding excessive dosage of the index drug(s), it is unclear whether the postulated drug-related condition is dose-dependent: if it is not, then the identified breach is not material."

40. At the conference, Dr. Punt advised that at trial Mr. Duffield would be able to establish a breach of duty by the Trust in that the TB nurse had told Dr. Yugambaranathan that Mr. Duffield's blood tests were normal when they were not. The effect of her failing to do this meant that when Dr. Yugambaranathan discussed *Rifinah* with Mr. Duffield, he only

explained the normal complications of the drug. Dr. Punt advised that had Dr. Yugambaranathan known that the LFTs were abnormal he would have advised differently and Mr. Duffield would not have taken the *Rifinah* at all.

41. With respect to causation, Dr. Punt said that he was satisfied on the basis of Professor Moore's evidence that there was a 51% chance of demonstrating that Mr. Duffield would not have developed PBC had he not taken *Rifinah*. Dr. Punt said that he did not put the matter higher because Professor Moore's opinion is not supported by Professor Walley, and "it is certain that the Defendant will find an expert who takes that view too." Accordingly, Dr. Punt advised that a claim against the Trust for prescribing the *Rifinah* could be made out at trial.

42. With respect to the overdose of *Rifinah*, Dr. Punt advised that there was a question as to who the Defendant should be in this respect: he advised that Dr. Gandhi might defend the claim on the basis that he was not an expert in respiratory illnesses and medicine and relied on what the TB expert (Dr. Yugambaranathan) told him to do. Dr. Punt advised, however, that Dr. Gandhi should be sued, to which Mr. Wynne noted that "there will be a problem regarding limitation in this respect". Dr. Punt said that they would have to consider "how we deal with the limitation problem". (In fact, by the time of the conference, Dr. Gandhi had died and this was mentioned by Mr. Duffield. This would obviously have a bearing on the limitation issue).

43. At the conference, Dr. Punt also stated that the case based on the overdose was "more difficult . . . because the consequences may have been the same due to the normal dose anyway". They would have to rely on the overdose "making more than a minimal difference." He thought they could do so on the basis of Professor Moore's evidence with respect to the PBC, but he was more concerned regarding the POTS and Dr. Hayat's evidence. Dr. Punt said that Dr. Hayat's report "was full of terms like possible, could etc. which are not nearly sufficient to prove legal liability. He has been better today in conference but I am worried that he slip back under cross examination." Dr. Punt was concerned that "SH might back down and not be as strong as he was today in discussion."

44. Overall, Dr. Punt advised that his "risk assessment is that there is a greater than 50% chance of establishing a negligent cause for the PBC but less than 50% chance of proving the POTS". He said that "Before making a final decision I need to see what SH [Dr. Hayat] will put in writing." Dr. Punt said that the plan would be to apply for further time to serve Particulars of Claim, and that they would issue against the GP. He said that he would review his opinion regarding POTS when he saw what Dr. Hayat put in writing. Dr. Punt concluded the conference by saying that he was not promising that Mr. Duffield's claim would succeed, but he thought it was more likely than not to succeed in some respects.

45. In the Defence to this claim, it is averred at paragraph 75 that Mr. Wynne spoke to Dr Punt by telephone on July 25th 2016, during which call Dr. Punt advised not to issue proceedings against the GP immediately. His advice was that the limitation period for such a claim had expired and the GP's negligence would not break the chain of causation vis-à-vis the Trust. Dr. Punt sent Mr. Wynne a list of questions for a GP expert. A report was subsequently obtained from an expert, Dr. Desor, who confirmed that the prescription by Dr. Gandhi of the excessive dose of *Rifinah* had been negligent, but did not constitute gross negligence. Accordingly, Dr. Gandhi's negligence would not break

the chain of causation from the hospital's negligence in referring to the wrong dose of *Rifinah* in the letter of September 19th 2001.

46. In further email correspondence, Mr. Duffield and Mr. Wynne discussed the question of limitation for the claim against the GP. On October 7th 2016, Mr. Wynne emailed Mr. Duffield to say that he did "believe limitation is an issue regarding some of the potential allegations against your GP, it is more than 3 years since you knew or should have known his actions caused you to suffer injury". On October 10th 2016, Mr. Wynne emailed Mr. Duffield on the limitation point and said that the matter was complicated by

> "it only being at the time Dr Branley's report was received that you advised in detail of your recollection that it was your GP who prescribed the drug and when. Prior to this on the basis of the medical records and what you had said, it was assumed you had received the overdose from the hospital. Hence protective proceedings were only issued against the Trust."

Mr. Duffield did not respond to this email to contradict what Mr. Wynne had said.

47. Also on October 7th 2016, Mr. Wynne informed Mr. Duffield that the ATE insurer, Temple, had reviewed his case on a recent audit and had requested a full report. Mr. Wynne said he would provide them with this, but also thought that they would need to obtain a written Advice from counsel regarding the prospects of the claim(s) succeeding in due course. On November 3rd 2016, Mr. Wynne sent a report to Temple, explaining Dr. Punt's advice in conference, and that further input needed to be obtained from Professor Moore and Dr. Hayat before counsel could give "definitive advice".

48. After a period of delay, which appears to have been caused by the unavailability of the experts, an updated report was provided by Professor Moore and Dr. Hayat answered some further questions. Dr. Punt then produced his written advice. The advice is undated, but there is evidence that it was written on May 3rd 2017. In his advice, Dr. Punt stated that he maintained the view that the prospect of establishing a breach of duty of care against the Trust on account of the failures of the TB nurse and Dr. Yugambaranathan was 60%. However, he advised that it was "most improbable" that a claim would succeed that this breach caused any loss, as even had proper advice about *Rifinah* been provided to Mr. Duffield, given his "self-evident anxiety regarding the exposure to TB, it would be very difficult to persuade a Judge that he would have opted against the chemoprophylaxis". This was a change of advice from the view expressed in conference as to what Mr. Duffield would have done.

49. With respect to the claim against the GP, Dr. Punt took the view that, in spite of Dr. Desor's opinion that Dr. Gandhi was in breach of duty in prescribing the double-dose of *Rifinah*, "it will be too late at this stage to bring him into the case as Second Defendant. I agree with instructing solicitors." In other words, limitation had expired. Dr. Punt also advised that "In any event the major hurdle, as in many such cases, lies with medical causation." Dr. Punt advised that there was "no sustainable independent expert support for asserting that POTS would have been avoided absent the breaches."

50. As for the PBC, Dr. Punt advised that the position was "more difficult". He commented that:

> "Professor Moore's opinion provides a superficially logical basis for a causal connection, however this must be weighed against the opposing points made by Professor Whalley. I take into account the point regarding the difference between isoniazid and iproniazid, and the absence of any cases of Rifinah-induced PBC in the scientific literature. The latter is brought into focus by the long and extensive use of the drugs in question. The fact that the two Professors can take different views underlines the probability that should the matter come to Trial, it is inevitable that the Defendant will find expert evidence that is contrary to Professor Moore's analysis. In that circumstance, the Judge will put in the position of deciding a scientific question and it is improbable that (s)he will accept such an invitation, but will find in the Defendant's favour, given that the onus is on the Claimant to prove his case."

In conclusion, Dr. Punt advised that "the prospects of success do not exceed 50%".

51. Mr. Duffield was plainly disappointed with Dr. Punt's advice. A number of points of concern were sent to Mr. Wynne who forwarded them to Dr. Punt. In an email dated May 7th 2017, Dr. Punt explained that he had revised his opinion regarding prospects of success for the reasons set out in his written Advice as well as some other points:

> "**Re Pots**
>
> Dr Hayat's view in his written report raised the possibility that there might be a causal connection, but the language used in his written report fell below the power required to prove the case at Trial, the reason being that it did not amount to a probability as opposed to the weaker possibility. In conference Dr Hayat expressed his opinion in stronger terms raising the prospects of success with regards to proving that the POTS was caused by the isoniazid. Subsequently, Dr Hayat has not confirmed his opinion: indeed, he has effectively resiled form it. It therefore follows that the prospects of proving negligence as to the POTS is negligible.
>
> **Re PBC**
>
> I agree that Professor Moore did support a causal role for the isoniazid in the development of the PBC.
>
> Upon reading all of the papers again, I have reached the view that the prospect of proving the connection between the isoniazid and the PBC is less than 50%, where at conference I had been more optimistic. My reasons for taking this different view are as follows
>
> The best point that Professor Moore made was the reported effects of iproniazid. The other points are much weaker: only some cases of PBC are in males; there has to be more than proximity in time between taking a drug, even in overdose, and experiencing a disease process to prove a causal connection between the two.

> I have given considerable thought as to the hurdles that would stand in the way of Professor Moore's opinion, and set out my conclusions below:
>
> 1 Iproniazid is different, albeit slightly, from isoniazid.
>
> 2 Despite being in use for many years and having been given to a huge number of patients being monitored on account of having a contagious disease (TB), there is an absence of recorded associations between isoniazid and PBC . . . I am aware of the tendency for doctors to publish very rare or novel side effects, either in scientific articles, or to regulatory bodies, or to both, so the absence of such reports is very pertinent.
>
> 3 The effect is that Professor Moore would be asking the Court to accept a very rare or even unique reaction to a drug, based upon an effect seen with a slightly different drug in connection with production of anti-bodies. That would also raise the problem as to the role of antigens and antibodies concerning the cause and development of PBC.
>
> 4 Asked the simple question as to whether Professor Moore's theory is the probable cause of the PBC as opposed to only a possible cause, I take the view that a Judge would be more likely to prefer an opinion that Professor Moore's theory could be possible, but was not probable. The effect would be that the case would fail.
>
> 5 It is very difficult for Judges when they have to decide between two respectable views provided by respected experts, especially if one view has weak scientific support. It is important to remember that it is for the Claimant to prove his case and that if faced with difficult scientific evidence that the Judge cannot resolve, it is sufficient for the Judge to decide that the Claimant has simply failed to prove his case.
>
> 6 For these facts and reasons, I have concluded upon reflection that Mr Duffield's case has prospects of less than 50%."

52. On May 18th 2017, Mr. Wynne emailed Dr. Punt with some further points that had been made by Mr. Duffield, including further input that Mr. Duffield had obtained from Professor Moore and Dr. Hayat. In an email dated May 16th 2017, Professor Moore had told Mr. Duffield that "Overall in my opinion you should win but is quite clear you could equally lose. It is not a clear cut case. It is very much a 50:50 case as far as I can see, or more likely that you would lose based on the below". Dr. Punt responded later on May 18th 2017, and referred to Professor Moore's view that "he cannot say that on a balance of probabilities the Rifinah was material to the development of PBC."

53. As for Dr. Hayat's latest report, Dr. Punt noted that this appeared to satisfy the evidential test as Dr. Hayat was referring to the "most likely" explanation of what had happened. However, Dr. Punt commented that "Dr Hayat's best evidence is the temporal link between taking the drug and the onset of the symptoms" but there is a "marked absence

of reported POTS-type symptoms in the contemporaneous records." Dr. Punt also referred to the previous report from Dr. Hayat which was "couched in terms that fell below the necessary probative standard", and said that he was "very conscious that there is a real risk that Dr Hayat's evidence will weaken in the course of events, if the case was to proceed." Against this background, Dr. Punt said that he not seen any new evidence putting prospects at better than 50%, and that he "could not recommend that a prudent person with his own means should expend his own money on pursuing the case further. It is on this basis that I must, and do, advise discontinuance."

54. Mr. Duffield was clearly disappointed to read Dr. Punt's response. He informed Mr. Wynne of this and they engaged in further correspondence about next steps. Mr. Duffield asked Mr. Wynne to obtain a second opinion for him. Mr. Wynne explained to Mr. Duffield that he needed to report to the insurer Temple about counsel's advice as soon as possible. By email dated May 22nd 2017 (at 10:17), Mr. Duffield said that if Mr. Wynne felt that he still had a case "no matter how small the amount then please pursue it. (if you believe it can be justified)", but also said that if they believed "that he did not have any claim to pursue then he trusted their final decision" and he wished for the case to be closed. Mr. Wynne responded (at 14:04) and said that the matter was not so "straight forward", and explained that "On the basis of your prospects of succeeding being assessed as less than 50% the Insurers won't fund your claim further and my firm will not continue to act on your behalf to do so." Mr. Wynne asked to speak with Mr. Duffield before taking any further steps.

55. On May 23rd 2017 (at 09:03), Mr. Wynne emailed Mr. Duffield to say that:

> "Normally having received unsupportive Counsel advice we would simply notify the Insurer of that and that we are therefore not proceeding with a claim . . . Yesterday you advised you did not wish to proceed with your claim and so this would be what I did here. In view of Counsel's advice and my own view of a claim on your behalf having less than 50% prospects of succeeding, my firm would not be willing to continue to act on your behalf pursuing this matter. As indicated the situation is complex hence my offer to speak with you to discuss."

Mr. Duffield responded (at 12:37) to say "please close the case as advised".

56. They had a further email exchange on May 25th 2017. In response to a question posed by Mr. Duffield as to whether he had ever known a barrister to "back out of a case after he gave support at conference", Mr. Wynne said that "Counsel reviewed the further evidence provided which was obtained after the conference." Mr. Wynne informed Mr. Duffield that, although he did not support his criticisms of Dr. Punt, Mr. Duffield could make a complaint about Dr. Punt to his Chambers.

57. As for whether another opinion could be sought from another barrister, Mr. Wynne said that "Other Counsel would not likely do so on a No Win- No Fee basis and would therefore need paying. My firm will not be willing to continue to act on your behalf, including instructing another barrister." In his witness statement, Mr. Wynne has stated that "In 25 years of practice, I have never sought a free second opinion on a case from "friendly" Counsel and I find the idea of doing so in this case ridiculous. It would have taken days to get to grips with the claim in order to form a considered opinion." Mr.

Wynne also says that "I am sure that Temple would have cancelled the ATE policy even if another barrister had given a more positive informal opinion. I would still have had to send Temple Dr Punt's advice and subsequent emails. They were already uncomfortable about the claim and they would not have been influenced by a second opinion of this kind."

58. In response to Mr. Duffield's request that his thoughts be shared with the insurers, Mr. Wynne said that "Having received unsupportive Counsel advice we would simply notify the Insurer of that and that we are therefore not proceeding with a claim . . . You have repeatedly advised you do not wish to proceed with your claim and so this would be what I did here. Providing "your thoughts" to the Insurer would have to serve some purpose."

59. The following day (May 26th 2017), Mr. Duffield emailed to say that he was "still unhappy with this" and asked Mr. Wynne to "seek another opinion from another barrister. if possible". Mr. Wynne emailed in reply that "In accordance with your instructions I have written to the Trust today notifying them that you are not pursuing your claim and inviting them to agree a Court order finalizing conclusion of the Court proceedings." Mr. Wynne said that he had already advised about getting another barrister's opinion. He concluded by saying that "You have repeatedly said you do not wish to speak to discuss the various issues and that I should end your case. I am proceeding in accordance with your instructions."

60. Mr. Duffield made a complaint about Dr. Punt to his chambers. His complaint was rejected. In correspondence, the Senior Practice Manager of Dr. Punt's chambers explained that it was "possible (although extremely unlikely)" that another barrister may take a different view of his prospects of success, and so he suggested that Mr. Duffield speak to his solicitor to see if it was possible to obtain a second opinion. On June 9th 2017, Mr. Duffield emailed Mr. Wynne to say that if he could not ask the opinion of another barrister, he would contact the Legal Ombudsman with respect to Dr. Punt and his chambers. Mr. Wynne responded on June 12th 2017 to say that he had to advise Temple as to the position, and that his firm would not be willing to continue to act on his behalf.

61. Mr. Wynne pointed out that they were awaiting a date for the hearing of Mr. Duffield's application to extend the time for service of substantive proceedings (an extension had been granted to April 27th 2017, and an application had been made to extend it to July 28th 2017), and that they were under time pressure to confirm what was intended regarding future conduct of the case. The claim was subsequently discontinued, with no order as to costs, on June 27th 2017.

62. In his witness statement, Mr. Wynne asserts that Dr. Punt was "ideal Counsel" to act in respect of Mr. Duffield's potential claim. Mr. Wynne says that Dr. Punt was a dual-qualified medical doctor and barrister with extensive experience, and he was well respected in his conduct of medical negligence claims. Furthermore, Mr. Wynne said that he "found no cause to doubt or question" Dr. Punt's advice. It was "thorough and well-reasoned". Mr. Wynne also explained that "Dr. Punt's advice was in accordance with the views I had formed myself by that stage". Mr. Wynne also stated that he "shared Dr Punt's concern that there was a real risk of Dr Hayat's evidence weakening as the claim progressed."

II. The Claim against the Defendant

63. On August 5th 2020, proceedings were issued by Mr. Duffield against the Defendant. In the Particulars of Claim, it was averred at paragraph 53 that "On 19 June 2012 the Claimant telephoned Sion Wynne to tell him that he believed, on reviewing the records, that he had received an overdose of Rifinah. This was on the basis that he had originally been prescribed 300mg twice a day by the hospital but his GP had mistakenly prescribed him 300mg four times a day as a result of a typographical error in the hospital consultant's letter". At paragraph 57, it was averred that "Professor Whalley was instructed in October 2013 and produced a report dated 18 November 2013. He concluded that the Claimant had been prescribed an excessively high dose of Rifinah which led to him suffering a form of drug induced hepatitis which was symptomatic but from which he had recovered by March 2002, at least biochemically."

64. At paragraph 60, it was averred that "In July 2014 Sion Wynne wrote to the Claimant pointing out that arguably the limitation period was about to expire (in respect of a claim based on the prescription of Rifinah) but explaining that it was not possible to issue proceedings without supportive evidence. However, no attempts were made to seek a moratorium from the Trust at this stage." At paragraph 62, it was averred that following the initial indications from Professor Moore that there was a link between *Rifinah* and the Claimant's liver problems "This led Sion Wynne to reconsider the position and to agree to issue a claim form on 10 February 2015 with the Trust as a Defendant. The claim form was limited to £15,000 and was intended to stop the limitation clock. It was issued less than 3 years after the Claimant had discovered that he had received an overdose so was '*in time'* for the purposes of sections 11 and 14 of the Limitation Act 1980." At paragraph 88, it was averred that "Following receipt of Dr Desor's report [on September 21st 2016] the Defendant took no steps to protect the Claimant's position in respect of a claim against the GP which was arguably now out of time."

65. At paragraph 116, it was averred that at the time the claim was discontinued, there was supportive expert evidence on breach of duty from Professor Branley for a claim against the Trust; supportive expert evidence on breach of duty from Dr. Desor for a claim against the GP but the Defendant "had not even written a letter of claim to the GP"; there was supportive evidence on causation in respect of PBC from Professor Moore and in respect of POTS from Dr. Hayat. Furthermore, "The Defendant did not know whether either the Trust or the defendant GP would dispute breach of duty or causation in respect of PBC or causation in respect of POTS because the Defendant had never set out its case on those issues to either potential defendant."

66. Twelve particulars of negligence were pleaded at paragraph 118:

> (a) In June 2017 the Defendant advised discontinuance of the claim against the Trust and abandoning any potential claim against the GP in circumstances where the Claimant had supportive expert evidence on breach of duty against both Trust and GP and on causation in respect of PBC and POTS and in circumstances where it was not even known whether, let alone on what basis or how strongly, the Trust and/or the GP would defend the claim.
>
> (b) Accepted without question the advice of Dr Punt that the prospects of success in respect of the 'PBC case' were less than 50%

notwithstanding that previously and on the same evidence he had put prospects at 51%.

(c) Accepted without question the advice of Dr Punt in his email of 18 May 2017 that the prospects of success in respect of the 'POTS case' were less than 50% and that Dr Hayat's opinion '*would probably weaken*' when on the contrary Dr Hayat had provided a supportive written opinion on 16 May 2016.

(d) Failed after receiving Dr Punt's advice of 18 May 2017, whether formally or informally, to seek a second opinion from a different barrister. A solicitor with the experience of Sion Wynne, from a firm with the reputation of the Defendant, would not have had any difficulty obtaining an opinion on the merits of the case without charge from experienced junior or leading counsel specialising in medical negligence. A preliminary opinion could easily have been sought based on the reports of Professor Moore, Professor Branley, Dr Hayat and Dr Desor plus, if desired, the unsupportive opinion of Professor Whalley and the June 2016 conference note.

(e) Failed prior to discontinuance to offer the option to the Claimant of seeking an informal second opinion. Instead the Claimant was put in an impossible position by being offered a second opinion only if he paid for it. It is accepted that there is no universal entitlement to a second opinion in a clinical negligence case but the circumstances here were that counsel who had provided the negative opinion did not have a long history in the case (having advised in conference once); had previously and on the same evidence advised in respect of the PBC claim that the prospects were greater than 50% and had now changed his mind; had previously been negative about the prospects of success in respect of the POTS claim but had made clear that a final opinion would be deferred until after receiving Dr Hayat's written report and having now received an updated causation report from Dr Hayat which was supportive (dated 16 May 2017) had nevertheless hardened his position to say that the prospects were less than 50%. At best, counsel's change of position was surprising and the circumstances justified the evidence being explored further with different counsel rather than the opinion simply being accepted unquestioningly.

(f) Failed to pay the correct issue fee when commencing the claim against the Trust in January 2015. In Lewis v Ward Hadaway [2015] EWHC 3053 (Ch) this practice was criticised by the High Court and found to be an abuse of process. That decision, in December 2015, post-dated the issue of proceedings in this case but would have left a reasonably competent clinical negligence solicitor concerned that the claim would be vulnerable to strike out, particularly when particulars of claim had still not been served in May 2017.

(g) Failed, following the decision in Lewis v Ward Hadaway, to review the Claimant's case and seek an order for permission to

> increase the value on the claim form. Had this step been taken either the Trust and the court would have allowed this step or the Defendant would have known that proceedings had not been validly issued and would/should have recommenced proceedings validly.
>
> (h) Failed to progress the claim with reasonable speed and diligence such that having been instructed in relation to the Rifinah claim in December 2011 proceedings were only issued against the Trust in January 2015 and particulars of claim had still not been served in May 2017. That failure would have left a reasonably competent clinical negligence solicitor concerned that the claim would be vulnerable to a strike out application.
>
> (i) Failed to investigate a claim of breach of duty against the GP between December 2011 and the obtaining of Dr Desor's report in September 2016. This failure included missing the primary limitation deadline for a claim against the GP (as acknowledged by Mr Wynne in his conference note from June 2016).
>
> (j) Failed to take any steps to protect the Claimant's position on limitation against the GP, whether by issuing protectively or seeking a limitation extension/moratorium with the GP.
>
> (k) Failed at any time after the June 2016 conference to advise the Claimant that the limitation deadline had been missed for a claim against the GP and that this created a conflict of interest between the Claimant and the Defendant. A reasonable litigant in the position of the Claimant would have been concerned to know that continuing the claim against the Trust and bringing proceedings out of time against the GP might have put the Defendant in a position where its conduct in failing to issue earlier against the GP was criticized by the court and let to a claim against the GP being struck out. Such a finding would inevitably have led to a negligence claim against the Defendant. The potential difficulty would be avoided if the Claimant accepted advice to abandon both claims. The Claimant was entitled to consider whether the advice was influenced by the opportunity for the Defendant solicitor to avoid criticism and a potential negligence claim.
>
> (l) Failed to advise the Claimant at any time as to the potential value of his claim. The Claimant could not properly decide whether or not to abandon his claim without knowing what he was giving up."

67. With respect to "Causation and loss", at paragraph 119 of the Particulars of Claim, the pleading stated that:

> "(m) The Claimant's PBC and POTS were caused or materially contributed to by the negligence of the Trust and/or the Claimant's GP, specifically by the prescription of Rifinah and/or the overdose of Rifinah.

> (n) Had the Defendant acted reasonably in the management of the original claim, including commencing proceedings validly (at the right value) against the Trust, issuing protectively against the GP, serving proceedings and continuing the claim, querying the advice of Dr Punt to abandon the claim, obtaining a second opinion from other counsel then it is probable that a claim would have succeeded, whether by trial or settlement, against the Trust and/or GP.
>
> (o) The Claimant contends that overall his prospects of securing a successful outcome (agreement for damages or success at trial) were of the order of 60% + and the Defendant's negligence deprived him of this chance.
>
> (p) It is likely that had the claim against the Trust and/or the GP been pursued with reasonable care and skill it would have resolved between about December 2018 (some 18 months after Dr Punt's final written advice advising that the claim be abandoned) and June 2019.
>
> (q) The probable value of the 'lost' claim is set out in the . . . schedule and the Claimant seeks a proportion of this figure to reflect the lost chance of success."

68. The Defendant submitted a Defence to the claim in which the allegations of negligence were denied. At paragraph 46 of the Defence, the Defendant admitted paragraph 53 of the Particulars of Claim: that is, that Mr. Duffield had told Mr. Wynne on June 21st 2012 that he had been overprescribed *Rifinah* by his GP. This admission echoed what had been set out in a response to a letter before claim written by solicitors for the Defendant on December 4th 2019:

> "On 19 June 2012 our client received a call from your client to inform it that he had been reviewing his medical records which indicated that he had received an overdose of Rifinah. Whilst he had initially been prescribed 300mg twice a day by the hospital, he believed that in October 2001 he was mistakenly prescribed 300mg four times a day by his GP (it would appear due to a typographical error in the hospital consultant's letter)".

69. Later on in the Defence, however, the Defendant pleaded (at paragraph 63) that "Following receipt of Prof Branley's report [in October 2015], Mr Wynne discussed the circumstances in which Rifinah had been prescribed with the Claimant, who revealed for the first time that the overdose had been prescribed by his GP rather than the Trust." Similarly, at paragraph 118, the Defendant pleaded that

> "(i) There was no reason to consider a claim against the Claimant's GP until the Claimant informed LM for the first time following receipt of Prof Branley's report dated 11 October 2015 that the overdose of Rifinah had been prescribed by the GP. (ii) At that date, Mr Wynne was reasonably entitled to take the view that (i) the limitation period for a claim against the GP had already expired (through no fault of LM's); (ii) the Trust would in any event be responsible for the mis-

> prescription and (iii) a claim against the GP would add nothing to a claim against the Trust."

70. These further averments echoed what had been set out in the Defendant's response to the letter before claim. It had been written that:

> "it was unknown to our client that his GP (Dr Ghandi) might be responsible for having prescribed the overdose until issues in respect of your client's medical records were raised by Dr Branley following receipt of his report in October 2015. Prior to this, our client had understood that the hospital was responsible for prescribing the drug, as stated in Dr Yugambaranathan's letter dated 19 September 2001 and as considered in the complaints process with the Trust. It was not until your client began to revisit events that it transpired that Dr Ghandi might bear some responsibility for the incorrect prescription."

71. At paragraph 52 of the Defence, the Defendant averred that "One of the reasons given for not commencing proceedings" against the Trust in July 2014 was that "Temple would not agree to it."

72. In the Defence, it was pleaded that certain of the particulars of negligence were not accompanied by a pleaded case on causation: sub-paragraphs (f), (g) and (h).

73. The Claimant has not served a Reply. Neither party has sought permission to amend their pleadings, or invited the Court to adjourn these applications pending amendment to their pleadings.

III. The Applications for Summary Judgment/Strike Out

74. The Defendant has made an application for summary judgment in respect of paragraphs 118(a) to (e) of the Particulars of Claim, alternatively for those paragraphs to be struck out as disclosing no reasonable grounds for bringing those claims; and to strike out paragraphs 118(f) to (l) as disclosing no reasonable grounds for bringing those claims.

75. The Claimant applies for summary judgment with damages to be assessed.

76. There was no dispute before me as to the proper approach that the Court should take to dealing with these applications:

i. *Strike out*: The Court may strike out a statement of case if it appears that it discloses no reasonable grounds for bringing or defending the claim: CPR 3.4(2)(a). This includes the situation where a claim is bound to fail because an essential element of the claim has not been pleaded.

ii. *Summary judgment*: The Court may give summary judgment against a claimant or defendant on the whole of the claim or a particular issue if (a) it considers that the relevant party has no real prospect of succeeding; and (b) there is no other compelling reason why the case or issue should be disposed of at trial: CPR 24.2.

77. The applicable principles for dealing with a summary judgment application were set out by Lewison J. in *Easyair Ltd (t/a Openair) v Opal Telecom Ltd* [2009] EWHC 339 (Ch) at [15]:

i) The court must consider whether the claimant has a "realistic" as opposed to a "fanciful" prospect of success: *Swain v Hillman* [2001] 2 All ER 91;

ii) A "realistic" claim is one that carries some degree of conviction. This means a claim that is more than merely arguable: *ED & F Man Liquid Products v Patel* [2003] EWCA Civ 472 at [8];

iii) In reaching its conclusion the court must not conduct a "mini-trial": *Swain v Hillman*;

iv) This does not mean that the court must take at face value and without analysis everything that a claimant says in his statements before the court. In some cases it may be clear that there is no real substance in factual assertions made, particularly if contradicted by contemporaneous documents: *ED & F Man Liquid Products v Patel* at [10];

v) However, in reaching its conclusion the court must take into account not only the evidence actually placed before it on the application for summary judgment, but also the evidence that can reasonably be expected to be available at trial: *Royal Brompton Hospital NHS Trust v Hammond (No 5)* [2001] EWCA Civ 550;

vi) Although a case may turn out at trial not to be really complicated, it does not follow that it should be decided without the fuller investigation into the facts at trial than is possible or permissible on summary judgment. Thus the court should hesitate about making a final decision without a trial, even where there is no obvious conflict of fact at the time of the application, where reasonable grounds exist for believing that a fuller investigation into the facts of the case would add to or alter the evidence available to a trial judge and so affect the outcome of the case: *Doncaster Pharmaceuticals Group Ltd v Bolton Pharmaceutical Co 100 Ltd* [2007] FSR 63;

vii) On the other hand it is not uncommon for an application under Part 24 to give rise to a short point of law or construction and, if the court is satisfied that it has before it all the evidence necessary for the proper determination of the question and that the parties have had an adequate opportunity to address it in argument, it should grasp the nettle and decide it. The reason is quite simple: if the respondent's case is bad in law, he will in truth have no real prospect of succeeding on his claim or successfully defending the claim against him, as the case may be. Similarly, if the applicant's case is bad in law, the sooner that is determined, the better. If it is possible to show by evidence that although material in the form of documents or oral evidence that would put the documents in another light is

> not currently before the court, such material is likely to exist and can be expected to be available at trial, it would be wrong to give summary judgment because there would be a real, as opposed to a fanciful, prospect of success. However, it is not enough simply to argue that the case should be allowed to go to trial because something may turn up which would have a bearing on the question of construction: *ICI Chemicals & Polymers Ltd v TTE Training Ltd* [2007] EWCA Civ 725.

(i) The Claimant's application for Summary Judgment

78. The Claimant's application for summary judgment is worded to apply to the whole claim. In his skeleton argument and orally before me, Mr. Stevenson mainly focused on the way in which the Defendant had handled the claim against the GP. Mr. Stevenson contended that it was beyond doubt that Dr. Gandhi was in breach of duty for the excessive prescription of *Rifinah*, and he should have been sued for his own mistake, even though the over-prescription was mentioned in the hospital's letter of September 19th 2001.

79. Mr. Stevenson submitted that no reasonably competent solicitor would not have sued the GP, especially as Mr. Wynne was already thinking (as at February 2015) that the claim was time-barred as against the Trust. Although it was now said by Mr. Wynne that Mr. Duffield had not told him that it was the GP who had prescribed the overdose, the matter had been admitted in the Defence, and this was also reflected in the response to the letter before claim. Professor Walley had also referred to his belief that the GP had issued the over-prescription in his letter and report . Mr. Stevenson contended that had the claim been prepared with reasonable diligence and issued in time it was overwhelmingly probable that a satisfactory settlement could have been achieved, and that the assessment of damages had to be considered at the date when limitation for the GP claim had expired.

80. Mr. Stevenson argued that the advice obtained from Dr. Punt was not relevant to that assessment of damages, as the advice was provided after limitation had expired. Mr. Stevenson contended that had Mr. Wynne acted diligently and obtained reports in 2014, which he should have done, it is unlikely that Mr. Wynne would have received the same advice. It was argued that Mr. Wynne might have gone to different counsel for advice.

81. Mr. Stevenson submitted that even if (which he did not accept) there was a question mark over causation in tort, Mr. Duffield was entitled to nominal damages for breach of contract. There had been a breach of the duty of care in failing to issue a claim against the GP in time.

82. In the hearing before me, Mr. Stevenson also argued that summary judgment should be ordered with respect to the claim against the Trust for prescribing *Rifinah* in the first place. He contended that, with reasonable diligence, this claim could and should have been issued by August 2014, so that limitation problems would have been avoided on this ground of negligence. (Mr. Carpenter QC has questioned whether Mr. Stevenson was seeking summary judgment on these allegations. It appeared to me that he was, and I will address the arguments in this judgment. As I will explain, the Defendant's summary judgment application, however it is put, did not succeed).

83. In response to this application, Mr. Carpenter QC contended that Mr. Duffield's application for summary judgment should fail for the same reason that the Defendant's

application should succeed (see further below). Alternatively, the application should fail because there is at least a triable issue as to causation, and a defence to the allegation of breach of duty has a real prospect of success.

84. Mr. Carpenter QC contended that Mr. Duffield's claim with respect to the handling of a potential claim against the GP hinged on a key factual issue which can only be resolved at trial, namely whether Mr. Wynne was aware before October 2015 that it was Dr. Gandhi (the GP), rather than the hospital, who had prescribed the overdose of *Rifinah*. The pleaded case was not what Mr. Wynne *ought* to have known but was based on actual knowledge. Mr. Carpenter QC submitted that the admission in the Defence to the Claimant's pleaded case at paragraph 53 (see paragraph 68 above) went further than the Defendant had intended it to, and that they would make an application to withdraw the admission if necessary.

85. In addition, Mr. Carpenter QC contended that even if Mr. Wynne had been aware that it was the GP who had over-prescribed *Rifinah* it did not follow that any reasonably competent solicitor would have named the GP as a defendant in the claim form. Mr. Carpenter QC argued that the GP was clearly following the instructions in the letter from the hospital, and adding the GP as a defendant to the claim would have increased the adverse costs exposure, without increasing the strength of the claim, at a time when there was limited evidence to support a claim on causation. The claim against the GP for over-prescription was a subset of the claim against the Trust: the claim against the Trust related to the prescribing of *Rifinah* in the first place, as well as the Trust's responsibility for the overdose. Mr. Carpenter QC submitted that the latter claim fell within the ambit of the claim form, and had been brought in time. As for the former claim, this was also within the ambit of the claim, and the Court would have extended time under section 33 of the Limitation Act 1980 if that was necessary.

86. Mr. Carpenter QC also contended that the Claimant had not pleaded that proceedings should have been issued against the Trust by August 2014 so as to avoid limitation problems. Mr. Carpenter QC contended that that allegation could not be found in paragraph 118(h) of the Particulars of Claim, and that the language of that paragraph could be contrasted with paragraphs 118(i) and (j) which refer specifically to limitation with respect to the claim against the GP.

87. Mr. Carpenter QC also contended that Mr. Stevenson's arguments on the Claimant's application for summary judgment did not address the various allegations of negligence arising from or related to Dr. Punt's advice. To the contrary, the Claimant's application was premised on the argument that the "die was cast" before Dr. Punt had even advised. Accordingly, there could be no summary judgment in respect of all of the claim that had been brought by Mr. Duffield.

(ii) <u>The Defendant's application for Summary Judgment and/or Strike Out</u>

88. The Defendant applies for summary judgment and/or to strike out the claim. Mr. Carpenter QC contends that the Claimant's pleaded case is flawed because:

(i) the allegations relating to the discontinuance of his claim cannot stand given the advice from Dr. Punt as to prospects of success, in circumstances where the Claimant does not allege that counsel's advice was obviously wrong, and no claim is made against counsel; and

(ii) there are obvious causation difficulties arising from counsel's advice: the effect of that advice was that it was inevitable that funding would be pulled by the insurer Temple and without that funding the case could not proceed.

89. With respect to (i), Mr. Carpenter QC submitted that in any professional negligence claim, the claimant must prove that an alleged error was made which "no reasonably competent member of the relevant profession would have made" (*Arthur J S Hall & Co. v. Simons* [2002] 1 AC 615 at 737G per Lord Hobhouse); and a solicitor should not be judged by the standard of "a particularly meticulous and conscientious practitioner . . . The test is what a reasonably competent practitioner would do having retard to the standards normally adopted in his profession" (*Midland Bank Trust Col. Ltd. v. Hett, Stubbs and Kemp* [1979] Ch 383 at 403, per Oliver J). Further, that solicitors are ordinarily entitled to rely upon the advice of counsel properly instructed: see *Locke v Camberwell Health Authority* [2002] Lloyd's Rep PN 23 at 29 per Taylor LJ, and that if a solicitor "reasonably thinks counsel's advice is obviously or glaringly wrong, it is his duty to reject it." This principle applies also to solicitors having specialist experience: see *Matrix Securities Ltd. v. Theodore Goddard* [1998] PNLR 290 at 323, per Lloyd LJ. The Claimant's counsel, Mr. Stevenson, did not take issue with these propositions, and I accept them as accurate statements of the relevant law.

90. With respect to (ii), Mr. Carpenter QC contended that the evidence given by Mr. Wynne as to Temple's approach to prospects of success, and as to his firm's approach to CFAs, and the centrality of counsel's advice in an assessment of the merits when deciding whether to maintain cover or continue with a CFA, is credible, makes commercial sense and is consistent with the contemporaneous documents.

91. In his submissions, Mr. Carpenter QC addressed each of the allegations of negligence as follows. With respect to paragraph 118(a) – *advising discontinuance* – Mr. Carpenter QC submitted that there was no real prospect of the Claimant establishing breach of duty or causation. In advising discontinuance, Mr. Wynne did exactly what had been advised by Dr. Punt, after reaching the conclusion that the claim had less than 50% prospects of success. Mr. Wynne was entitled to rely on that advice. As a matter of causation, even if Mr. Duffield had advised Mr. Wynne not to discontinue, he would have had to notify Temple of the advice and ATE cover would have been withdrawn in any event, and the Defendant would have terminated the CFA.

92. With respect to paragraph 118(b) – *Accepting Dr. Punt's advice "without question"*- Mr. Carpenter QC submitted that this is wrong in fact as Mr. Wynne did question the advice of Dr. Punt. In any event, there is no pleaded case that Dr. Punt would have reassessed prospects as being over 50% if Mr. Wynne had questioned Dr. Punt's advice further.

93. With respect to paragraph 118(c) – *Dr Punt's email of 18 May 2017 that the prospects of success in respect of the 'POTS case' were less than 50% and that Dr Hayat's opinion* '*would probably weaken when Dr Hayat's advice was supportive* – Mr. Carpenter QC contended that the advice from Dr. Punt should not be atomised by focusing on one email, but what should be asked is whether Mr. Wynne was reasonably entitled to rely on Dr. Punt's overall advice. That is particularly so with respect to the connection with POTS where Dr. Punt's advice had been consistent throughout. Mr. Carpenter QC submitted that, in fact, Dr. Punt's advice was that there was a "real risk" that Dr. Hayat's opinion would probably weaken and that there were other reasons given for concluding that the latest report from Dr. Hayat was not sufficient. In any event, Dr. Punt was entitled to be

concerned about Dr. Hayat's advice weakening as his opinion had fluctuated over time. Further, Mr. Wynne had applied his own mind to the claim and was also concerned about Dr. Hayat's evidence. Mr. Carpenter QC also contended that this allegation will founder in any event on causation.

94. With respect to paragraphs 118(d) and (e) – *Failing to seek a second opinion; and Failing to offer the option of a second opinion* – Mr. Carpenter QC contended that there was no real prospect of Mr. Duffield establishing a breach of duty: it was wholly unrealistic to consider that every reasonably competent solicitor who had received a detailed and coherent advice from formally instructed counsel in a complex clinical negligence claim would obtain or offer to obtain an unpaid second opinion before abandoning a claim. It is also not pleaded that another barrister would have reached a different conclusion. In any event, these allegations founder on causation, as Temple would have seen Dr. Punt's opinion and Mr. Wynne's view that Temple would not have been influenced by a second opinion cannot be contradicted.

95. With respect to paragraphs 118(f) and (g) – *Issue fee paid, Statement of value in the claim form* – Mr. Carpenter QC argued that there was no pleaded case on causation or loss, and Mr. Duffield has suffered no loss. The allegations are predicated on the claim being vulnerable to strike out, and yet that there had been no application by the Trust to strike out the claim.

96. With respect to paragraph 118(h) – *Failure to progress the claim with reasonable speed* – Mr. Carpenter QC argued that there was no pleaded case on causation or loss, and Mr. Duffield did not suffer any loss. The sting of the allegation was said to be that the claim was vulnerable to a strike out application, but no such application was ever made. A claim based on the failure to issue earlier against the Trust had not been pleaded.

97. With respect to paragraphs 118(i) and (j) – *Delay in investigating a claim against the GP, Failing to preserve limitation against the GP* – Mr. Carpenter QC contended that these allegations founder on the same causation problem as the claim against the Trust, irrespective of the question of limitation with respect to the GP. Dr. Punt had advised that prospects of establishing a linkage with PBC or POTS did not exceed 50%. Mr. Carpenter QC contended that although it was "conceivable" that a different barrister would have reached a different conclusion than Dr. Punt on the merits of the claim, that was not the way in which the case was pleaded. Furthermore, the identity of the barrister who advised was an "irrelevant detail" and, applying conventional principles of causation as expressed by various of their Lordships in the House of Lords decision in *Chester v. Ashfar* [2005] 1 AC 134, it can be said that in his selection of counsel Mr. Wynne had done nothing to change the risk to which Mr. Duffield was exposed.

98. With respect to paragraph 118(k) – *Alleged conflict of interest* – Mr. Carpenter QC submitted that there was no properly pleaded case on causation. Even if (which was not accepted) Mr. Wynne should have advised Mr. Duffield after the conference with Dr. Punt that missing the limitation deadline against the GP created a potential conflict of interest, the only proper response would have been for the solicitors Metamorph (the firm which was acting for the Claimant at this point) to cease acting for Mr. Duffield. There is no case pleaded as to what would have happened had they done so.

99. With respect to paragraph 118(l) – *Advice on the value of the claim* – Mr. Carpenter QC submitted that Dr. Punt's advice on the merits had to be reported to Temple, who would

have cancelled the ATE policy in any event, and the solicitors Linder Myers LLP would have terminated the CFA. There was no pleaded case as to what advice should have been given and how this would have led to the claim proceeding.

100. In response to the Defendant's application, Mr. Stevenson relied on the arguments that he made in support of the Claimant's application for summary judgment with respect to the particulars relating to the claim against the GP and the Trust.

101. As for the particulars of negligence related to discontinuance or abandonment of the claims, Mr. Stevenson was very critical of Dr. Punt's advice. Mr. Stevenson submitted that Dr. Punt had advised on an erroneous basis when he considered Mr. Duffield's prospects of success. Dr. Punt's focus was on trial whereas the overwhelming majority of clinical negligence cases settle, even those cases which have a 50% or lower prospect of success, and yet this did not form part of Dr. Punt's thinking. Furthermore, Mr. Stevenson submitted that Dr. Punt's reasons for dismissing C's prospects were all flawed, and that his advice should not have been relied upon by the Defendant.

My consideration of the applications

102. As there is an overlap between many of those particulars, I shall group together those allegations of negligence which share a common theme. I will also address the separate claims in contract and tort, as I am mindful that a claimant would be entitled to nominal damages where there has been a breach of the duty of care, even if tortious losses could not be proved: see *Chitty on Contracts* (33rd ed.) at 26-010.

(i) Allegations relating to advice on discontinuance/abandonment of the claim: particulars of negligence (a)-(e)

103. A number of the allegations of negligence concern the decision of Mr. Duffield to abandon his claim and/or the advice of Dr. Punt that the claim should be discontinued: allegations at (a)-(e).

104. With respect to paragraph 118(a) – *advising discontinuance* – I consider that at trial it is inevitable that Mr. Duffield would fail to establish that the Defendant (acting through Mr. Wynne) was in breach of the duty of care that was owed to him by advising discontinuance. As a result, both the claim in tort and contract are summarily dismissed.

105. Further, in any event, I consider that it is inevitable that at trial Mr. Duffield would fail to establish that Mr. Wynne's advice that the claim should be discontinued was causative of any loss: Temple would have been bound to withdraw the ATE cover and the Defendant would have been bound to terminate the CFA in light of Dr. Punt's written advice. Accordingly, the tort claim would also fail for this reason.

106. I reach this conclusion for the following reasons. Dr. Punt's advice was clear that Mr. Duffield's "prospects of success do not exceed 50%". I have no doubt that this advice was arrived at after very careful consideration by Dr. Punt of the available evidence, including the various expert reports. This is reflected not only in the undated written advice from Dr. Punt, but also in the subsequent email correspondence in which Dr. Punt elaborated on his advice. Mr. Wynne was, in my judgment, plainly entitled to rely on this advice. Moreover, Mr. Wynne says in his witness statement that he had reached the same view of the merits as Dr. Punt, and it seems most doubtful that this could be undermined

in cross-examination at trial, especially as it is evidenced by some of the documents which express Mr. Wynne's unease about the merits of the case.

107. The Particulars of Claim do not allege that it was negligent of Mr. Wynne to have instructed Dr. Punt, and I consider that it was appropriate for the Claimant not to make such an allegation. A brief perusal of Dr. Punt's page on his Chambers' website evidences his experience and expertise in the field of clinical negligence, and this expertise is reflected in the thoughtful questions posed by Dr. Punt to the various experts at the conference held in June 2016.

108. As for the quality of the advice that Dr. Punt gave, there are traces of criticism of the advice within the Particulars of Claim, but there is no specific pleading that the advice was actually negligent, let alone that the advice was "obviously" wrong, which would call into question Mr. Wynne's reliance on it. Mr. Stevenson was rather more forceful in his criticism of Dr. Punt's advice in his skeleton argument and in his oral argument before me, but this seemed to me to be unfair and not reflective of the contemporaneous materials. The evaluation of the evidence and assessment of the prospects of success was not a straightforward exercise, and I consider that Dr. Punt was entitled to conclude that the evidence on causation, although somewhat supportive of Mr. Duffield's claim, would not be sufficient for Mr. Duffield to succeed at trial.

109. With respect to the expert advice as to the connection with PBC, Dr. Punt's analysis in his written advice and in his subsequent email advice is convincing. In particular, I note Dr. Punt's reference to the fact (as explained by Professor Walley) that there no references to cases of Rifinah-induced PBC in the scientific literature, even though there had been long and extensive use of the drugs in question. Dr. Punt considered, and he was right to do so, that the defendants to the claim would undoubtedly find an expert who disagreed with Professor Moore. In those circumstances, I consider that Dr. Punt was reasonable in advising that in having to choose between competing experts the trial judge would be likely to find that the claimed causation with PBC had not been made out.

110. It is true that at the conference in June 2016, Dr. Punt had expressed the view that the claims with respect to PBC would probably succeed. However, he did not express a view that the claim was a strong one and so his change of mind was not evidence of negligent advice. Indeed, the final view reached by Dr. Punt was the same as his initial, and presumably instinctive, view of the merits which he shared with his clerk on first being instructed. I consider that the fact that Dr. Punt had changed his mind from the conference was entirely reasonable given that he was dealing with a case which at best was close to the 50:50 border. The written advice was Dr. Punt's more considered view having had time to re-read all of the material and reflect again on that material. The fact that Dr. Punt did not say at the conference that he needed to see more material about the PBC claim, or that he would reflect further on it does not undermine this analysis. The conference took place in June 2016 and the written advice was given almost a year later. It was entirely reasonable, given the passage of time, that Dr. Punt wished to re-read the material before expressing his definitive view in writing.

111. Dr. Punt's evaluation of Dr. Hayat's evidence and the connection of *Rifinah* with POTS, was also appropriate. Dr. Punt formed the view that Dr. Hayat had equivocated as to the strength of the causative connection and, having spoken to him directly in conference, was fully entitled to consider that there was "a real risk that Dr Hayat's evidence will weaken in the course of events" if the case was to proceed. This was the kind of judgment

which an experienced barrister was entitled to make, having read Dr. Hayat's different reports and having explored his opinion in conference.

112. In his written advice, Dr. Punt also changed his mind from the conference in June 2016 as to whether Mr. Duffield would have taken the *Rifinah* in the first place had he been advised properly by the Trust. Again, it seems to me that this revised advice was reasonable for Dr. Punt to arrive at after further reflection. As Dr. Punt explained in his written advice, "Given [Mr. Duffield's] self-evident anxiety regarding the exposure to TB, it would be very difficult to persuade a Judge that he would have opted against the chemoprophylaxis".

113. In the circumstances, I do not consider that a Court could find that Dr. Punt's advice on the merits was "obviously" wrong even though, as Mr. Carpenter QC candidly acknowledged, it was "conceivable" that other counsel may have come to a different conclusion. Accordingly, there is no doubt that at trial Mr. Duffield would fail to establish that Mr. Wynne breached his duty of care in relying on Dr. Punt's advice that prospects of success at trial did not exceed 50%.

114. As for what Mr. Wynne should have done having received Dr. Punt's advice, it is pleaded at paragraph 118(a) that discontinuance of the claim against the Trust and abandonment against the GP took place in circumstances where "it was not even known whether, let alone on what basis or how strongly, the Trust and/or the GP would defend the claim." The claim is, therefore, that Mr. Wynne should have sought to obtain a settlement from the Trust and/or the GP before the claim was discontinued. I do not consider that Mr. Duffield has a real prospect at trial of persuading the Court that no reasonably competent solicitor would have acted in the way that Mr. Wynne did, so that a claim for breach of the duty of care can be made out in this regard.

115. The pleaded case has to be considered in light of the actual circumstances that applied, rather than some hypothetical circumstances as to what a reasonably competent solicitor would do when they are managing a case which has some merit, and some supportive evidence on causation. The context here was that Temple was the ATE insurer, and Mr. Wynne's evidence is that Temple's requirement that claims have at least 51% prospects of succeeding at trial continues throughout the lifetime of the claim, and that "Withdrawal of the ATE cover would be the inevitable consequence" if Temple were informed that prospects were less than 51%, especially where this was the advice of counsel. Further, the context here was that Mr. Wynne's firm would end their CFA if a case was assessed as having less 51% prospects of succeeding at trial. I do not consider that this evidence could be undermined at trial. In addition to this being Mr. Wynne's evidence, there is also a commonsense rationale to what he was saying. Further steps would involve greater expense, and such steps would also increase the risk of having to pay the defendants' costs, and to increase the amount of those costs, if the claim did not settle and had to be discontinued before trial. It would not have been unreasonable for Temple and Metamorph to avoid those increased expenses and the adverse costs risk by simply bringing their involvement in the claim to an end.

116. With respect to paragraph 118(b) – accepting without question the advice of Dr. Punt with respect to the PBC case – this is a sub-set of the more generic case pleaded at paragraph 118(a) and the same analysis applies. Accordingly, both the claims in tort and contract are summarily dismissed. There is also a factual flaw in this allegation as Mr.

Wynne did not actually accept the advice "without question". Mr. Wynne was prepared to go back to Dr. Punt with the further points made by Mr. Duffield.

117. The same applies to paragraph 118(c) – accepting without question the advice of Dr. Punt with respect to the POTS case. Indeed, even more so, as Dr. Punt had never expressed the view that the POTS case was likely to succeed at trial. Both the tort and contract claims are summarily dismissed.

118. With respect to paragraph 118(d) – failing to seek a second opinion from a different barrister – this has no real prospect of success. Mr. Wynne has given evidence that he had never sought a free second opinion on a case from "friendly" counsel in 25 years of practice. I do not see how this evidence could be undermined in cross-examination. Moreover, there is no basis to contend that no reasonably competent solicitor would have adopted the same approach as Mr. Wynne: that is, that no reasonably competent solicitor would not have sought a further, free, opinion. Mr. Wynne had already obtained a definitive opinion from an experienced barrister, who had examined the facts and evidence in some detail; and counsel's opinion concurred with Mr. Wynne's own view. There was no proper basis to seek a further opinion. In the circumstances, as Mr. Duffield would not be able to establish a breach of the duty of care at trial, both the claims in contract and tort are summarily dismissed.

119. Furthermore, this allegation of negligence would founder on "causation", as it is inevitable that Temple would have acted on the advice of Dr. Punt, who had been formally instructed and had read through all of the materials with care, and ceased ATE cover, even if a more favourable "free second opinion" had been obtained.

120. In my judgment, paragraph 118(e) – failing to offer the Claimant the option of seeking an informal second opinion – is another way of putting the allegation at paragraph 118(d), and the claims in contract and tort are summarily dismissed for the same reasons.

(ii) Allegations relating to the issue fee and value on the claim form: paragraphs (f)-(g)

121. The Claimant pleads two allegations that relate to the issue fee and the value on the claim form. These allegations are summarily dismissed, both in contract and tort. Mr. Stevenson accepted in oral argument that the approach adopted by Linder Myers LLP to the value of the claim was something which was commonly practised by solicitors at the relevant time. On that basis, I do not consider how Mr. Duffield could succeed in showing that no reasonably competent solicitor would not have acted in the same way as happened in this case.

122. Further, even if there was a breach of the duty of care, the tort claim would fail as there is no basis on which Mr. Duffield could establish that he suffered any loss as a result. The claim against the Trust was not, in fact, subject to a strike out application and as the claim was not continued there was, in fact, no necessity to seek an order (or consent to an order) to increase the value on the claim form.

(iii) Allegations relating to the progression of the claim against the Trust: paragraph (h)

123. At paragraph 118(h), the Claimant pleads that the Defendant failed to progress his claim with reasonable speed and diligence. The Claimant contends that although the Defendant was instructed in relation to the *Rifinah* claim in December 2011, proceedings were only

issued against the Trust in January 2015 and Particulars of Claim had not been served in May 2017. At paragraphs 119(n)-(o), the Claimant pleads various ways in which the negligence caused him loss, some of which appears to be designed to follow from the alleged failure at paragraph 118(h). It seems to me that the relevant parts of paragraph 119(n) are that "Had the Defendant acted reasonably in the management of the original claim . . . then it is probable that a claim would have succeeded, whether by trial or settlement, against the Trust", and at paragraph 119(o): "The Claimant contends that overall his prospects of securing a successful outcome (agreement for damages or success at trial) were of the order of 60%+ and the Defendant's negligence has deprived him of this chance".

124. Mr. Stevenson contends that paragraph 118(h) includes a failure to issue against the Trust earlier than January 2015, and in time to avoid limitation problems: that would mean that the claim should have been issued by August 2014 as this was within 3 years of when Mr. Duffield first became aware that his LFT tests prior to the initial prescription of *Rifinah* by the Trust had been abnormal. I agree. This allegation falls comfortably within the overall heading of "Failed to progress the claim with reasonable speed and diligence such that having been instructed in relation to the Rifinah claim in December 2011 proceedings were only issued against the Trust in January 2015".

125. I appreciate that the pleading of negligence does not specifically refer to "limitation" with respect to the Trust, and this can be contrasted with the way in which the failure to issue proceedings in time against the GP is described at paragraphs 118(i) and (j). Nevertheless, it seems to me that the limitation point with respect to the Trust can be implied from the use of the word "only" in paragraph 118(h): that is, it is pleaded that it was negligent that "proceedings were *only* issued against the Trust in January 2015", which implies that the proceedings against the Trust should have been issued sooner than they were. This reading of paragraph 118(h) is supported by other averments in the Particulars of Claim: at paragraph 49 it is averred that "The Defendant identified the need to rely on constructive knowledge for the purposes of the Limitation Act 1980 and note that primary limitation might expire as early as August 2014 which was three years after the Claimant was told of his PBC"; and at paragraph 60 there is a reference to Mr. Wynne writing in July 2014 that "arguably the limitation period was about to expire (in respect of a claim based on the prescription of Rifinah) . . . However, no attempts were made to seek a moratorium from the Trust at this stage." The latter sentence specifically puts in issue the limitation point with respect to the claim against the Trust.

126. Mr. Stevenson also contends that paragraph 118(h) should be read to include a failure by the Defendant to obtain appropriate reports more expeditiously than was in fact the case, so that Particulars of Claim could have been issued at an earlier stage. I agree. Such a failure would comfortably fall within the overall heading of "Failed to progress the claim with reasonable speed and diligence such that having been instructed in relation to the Rifinah claim in December 2011 proceedings were only issued against the Trust in January 2015". It also seems to me that there is a thread within the narrative part of the Particulars of Claim that implies that the Defendant did not move sufficiently expeditiously so that experts who were supportive of the Claimant's case could be located and instructed earlier than had been the case.

127. At paragraph 52 of the Particulars of Claim it is averred that Mr. Duffield's medical notes were obtained in July 2012 and sent for review. As further records were requested, it is averred that "sufficient records to permit the instruction of an expert were not available

until mid-2013". This implies a delay in the gathering of documents for the purpose of instructing experts. There is reference at paragraphs 55 and 56 to the instruction of experts (Professor Davies who advised in May 2013; and Professor Walley who produced a report in October 2013) who were not supportive, but at paragraph 54 there is reference to the Claimant, having been diagnosed with POTS in addition to PBC, being informed by his treating consultants that there may be a link between "this condition and Rifinah". At paragraph 58, there is reference to "a significant delay which led to a complaint by the Claimant to the Defendant". There is then a reference to the Claimant suggesting to the Defendant they obtain opinions from his treating clinicians Professors Gamage and Neuberger (paragraph 59). This suggests that it was Mr. Duffield pushing the Defendant to locate supportive expert advice. At paragraph 61, it is averred that "The Claimant persuaded the Defendant to hold off from pulling out of the CFA and took his own steps to obtain expert evidence. He had found a hepatologist, Professor Moore, who had indicated that he would be willing to consider assisting. Professor Moore indicated that he felt that there was a link between the Rifinah and the Claimant's liver problems." The implication of this paragraph is that the Defendant could and should have located this expert had Mr. Wynne acted diligently, rather than rely on Mr. Duffield's efforts.

128. I consider that both of these matters – the failure to issue proceedings against the Trust earlier, and the failure to obtain supportive expert reports more expeditiously – might amount to a breach of the duty of care on the part of the Defendant, and should properly be put before a trial judge. I do not consider that the materials currently available to the Court allow me to reach a definitive judgment on those matters either way. At the very least, therefore, Mr. Duffield may be able to succeed on his claim for breach of contract.

129. As for the claim in tort, I have carefully considered the speeches of their Lordships in the House of Lords judgment in the case of Chester v Afshar. That case was concerned with the failure of a surgeon to warn the claimant of the small risk that she would develop post-operative paralysis if she underwent a surgical procedure on her spine. The trial judge found that the surgeon's failure to warn the claimant of the risk was negligent, that had the claimant been aware of the risk she would have sought advice on alternatives to surgery and the operation would not have taken place on the day that it did. The trial judge also found that the claimant had suffered injury as a result of the surgery, but the surgeon had not been negligent in his performance. The trial judge found that there was a possibility that the claimant would have consented to surgery in the future.

130. Their Lordships held that on conventional principles of causation, the claim for negligence would fail, as the risk to the claimant which eventuated was liable to occur at random irrespective of the skill and care with which the operation was performed, and so the surgeon's failure to warn the claimant about the risks of surgery did not affect the risk of injury, and was not the effective cause of the injury that the claimant suffered. The majority of the House of Lords held, however, that a departure from the conventional principles was called for as a matter of justice, so as to vindicate the claimant's right of choice and to provide a remedy for the breach of the failure to warn.

131. There is no basis to depart from the conventional principles of causation in this case, and Mr. Carpenter QC did not argue that a departure was required. Rather, he contended that on the conventional principles of causation, no loss was caused by the alleged negligence of the Defendant. In my judgment, however, it is not possible to conclude on the basis of the materials before me that no loss was caused by the Defendant's alleged negligence. It does not seem to me that the identity of the counsel instructed was an "irrelevant"

detail. It is possible that had the claim against the Trust been progressed more expeditiously, different counsel may have been instructed. As Mr. Carpenter QC acknowledged, different counsel may have reached a different, and more favourable, view of the merits. This would have allowed a claim against the Trust to go forward, which might have led to a settlement offer being made by the Trust or might have succeeded at trial. Accordingly, I cannot say at this stage that Mr. Duffield has not potentially lost something of real value.

132. This conclusion is, in my judgment, consistent with the statements of their Lordships as to the conventional principles. Thus, Lord Bingham stated at [8] that:

> "in the ordinary run of cases, satisfying the "but for" test is a necessary if not a sufficient condition of establishing causation. Here, in my opinion, it is not satisfied. Miss Chester has not established that but for the failure to warn she would not have undergone surgery. She has shown that but for the failure to warn she would not have consented to surgery on Monday, 21 November 1994. But the timing of the operation is irrelevant to the injury she suffered, for which she claims to be compensated. That injury would have been liable to occur whenever the surgery was performed and whoever performed it."

In Miss Chester's case, therefore, the "risk" that she would suffer her injury was the same, whenever the operation would have been conducted and whoever performed it. In the instant case, however, it cannot be said that the advice – and therefore the "risk" that Mr. Duffield would receive advice from counsel leading to the loss of ATE cover from Temple and the termination of the CFA by Metamorph -- would have been the same "whoever" gave it.

133. Lord Hoffman stated at [30] to [32] that:

> 30. The judge made no finding that she would not have had the operation. He was not invited by the claimant to make such a finding. The claimant argued that as a matter of law it was sufficient that she would not have had the operation at that time or by that surgeon, even though the evidence was that the risk could have been precisely the same if she had it at another time or by another surgeon. A similar argument has been advanced before this House.
>
> 31. In my opinion this argument is about as logical as saying that if one had been told, on entering a casino, that the odds on the number 7 coming up at roulette were only 1 in 37, one would have gone away and come back next week or gone to a different casino. The question is whether one would have taken the opportunity to avoid or reduce the risk, not whether one would have changed the scenario in some irrelevant detail. The judge found as a fact that the risk would have been precisely the same whether it was done then or later or by that competent surgeon or by another.
>
> 32. It follows that the claimant failed to prove that the defendant's breach of duty caused her loss. On ordinary principles of tort law, the defendant is not liable. . .

In the instant case, however, the identity of counsel was not an "irrelevant detail": different counsel may have given different and, in particular, more positive advice as Mr. Carpenter QC accepts. Accordingly, to apply Lord Hoffman's characteristically colourful example, there were different "odds" available to Mr. Duffield depending on which "casino" he frequented.

134. Lord Hope stated at [81] that:

> "I would accept that a solution to this problem which is in Miss Chester's favour cannot be based on conventional causation principles. The "but for" test is easily satisfied, as the trial judge held that she would not have had the operation on 21 November 1994 if the warning had been given. But the risk of which she should have been warned was not created by the failure to warn. It was already there, as an inevitable risk of the operative procedure itself however skilfully and carefully it was carried out. The risk was not increased, nor were the chances of avoiding it lessened, by what Mr Afshar failed to say about it."

In the instant case, however, the content of the advice that would be given by counsel was not "inevitable": it might have been more positive for Mr. Duffield.

135. Lord Walker stated at 94:

> "If a patient in the position of Miss Chester or Mrs Hart had been injured by some wholly unforeseeable accident of anaesthesia (the scenario suggested by Gummow J in *Chappel v Hart*, at p 257, para 66) or because the operating theatre was struck by lightning (Hayne J's more fanciful scenario at p 286, para 129) the injury could have been described as coincidental in the sense indicated by Mason CJ in *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506 , 516: "a factor which secures the presence of the plaintiff at the place where and at the time when he or she is injured is not causally connected with the injury, unless the risk of the accident occurring at that time was greater." When a traveller was delayed through a railway company's fault and a lamp exploded in the hotel where she was compelled to spend the night (the well-known case of *Central of Georgia Railway Co v Price* (1898) 32 SE 77) that was simply an unfortunate coincidence. Similarly, if a taxi-driver drives too fast and the cab is hit by a falling tree, injuring the passenger, it is sheer coincidence. The driver might equally well have avoided the tree by driving too fast, and the passenger might have been injured if the driver was observing the speed limit. But to my mind the present case does not fall into that category. Bare "but for" causation is powerfully reinforced by the fact that the misfortune which befell the claimant was the very misfortune which was the focus of the surgeon's duty to warn."

In the instant case, however, the identity of counsel instructed to advise as to the prospects of success was not "coincidental", as the "risk" to Mr. Duffield as to what different counsel might say was variable.

136. I appreciate that the Particulars of Claim do not say that different counsel might have been instructed with different advice to Dr. Punt. In my judgment, it was not necessary for this to have been expressly set out by the Claimant. The instruction of counsel falls within the ambit of the general words at paragraph 119(n) of the Particulars of Claim "Had the Defendant acted reasonably in the management of the original claim". Acting reasonably in the management of the original claim would include instructing counsel at an appropriate time, which include instructing different counsel to Dr. Punt.

137. With respect to this allegation, therefore, I cannot accede to the Defendant's application for summary dismissal and/or strike out. I cannot conclude that "but for" the Defendant's alleged breach of duty with respect to the progression of the claim against the Trust the same legal advice would have been provided, with the inevitable consequence that the claim would have been discontinued and abandoned by Mr. Duffield.

138. On the other hand, I am unable to accept Mr. Stevenson's contention, on behalf of the Claimant, that the defence to this part of the claim has no real prospect of success. There is, in my judgment, a realistic possibility that the Defendant will be able to show that there was no breach of the duty of care in how the claim against the Trust was handled: that a reasonably competent solicitor was not bound to have issued the claim earlier than the date on which Mr. Wynne did issue the claim, and that a reasonably competent solicitor was not bound to have acted more expeditiously in progressing the claim through the identification of supportive witnesses. These are matters for proper consideration by the trial judge.

(iv) Allegations concerning the delay in investigating a claim against the GP, and failing to preserve limitation against the GP: paragraphs (i) – (j)

139. At paragraph 118(i) of the Particulars of Claim, the Claimant complains about the failure to investigate a claim of breach of duty against the GP between December 2011 and September 2016, including missing the primary limitation deadline for such a claim. Paragraph 118(j) complains about the failure to take steps to protect the Claimant's position on limitation with respect to a claim against the GP. Causation and loss are pleaded at paragraph 119(n): "Had the Defendant acted reasonably in the management of the original claim, including . . . issuing protectively against the GP, serving proceedings and continuing the claim . . . then it is probable that a claim would have succeeded, whether by trial or settlement, against the . . . GP."

140. Mr. Stevenson contends that the claim for breach of duty is plainly made out: that Mr. Wynne was aware from June 2012 that the GP had overprescribed *Rifinah* and that a claim against the GP should have been issued in time, even if only protectively. I disagree. The claim with respect to the GP is premised on Mr. Wynne's actual, and not constructive, knowledge: in particular, at paragraph 53, the Claimant pleads that he telephoned Mr. Wynne on June 19th 2012 to tell him that he believed that he had received an overdose of *Rifinah*, and that this was on the basis that "his GP had mistakenly prescribed him 300 mg four times a day as a result of a typographical error in the hospital consultant's letter". There is clearly a dispute of fact as to what took place during that telephone conversation. Mr. Duffield maintains that he informed Mr. Wynne that it was the GP who had prescribed the overdose; Mr. Wynne says that that is not his recollection. The contemporaneous documentation does not make mention of who prescribed the overdose. The witness statement prepared by Mr. Wynne for Mr. Duffield, and which he signed on December 13th 2012, does not include the assertion that it was the GP who

prescribed the overdose. Mr. Wynne contends that the first time that he was made aware by Mr. Duffield that it was the GP who had overprescribed the *Rifinah* was October 12th 2015.

141. I appreciate that in the Defence (echoing what was written in the response to the letter before claim), there is an admission to paragraph 53. That admission is nevertheless plainly inconsistent with other parts of the Defence which are premised on Mr. Wynne not being told by Mr. Duffield that he had been overprescribed *Rifinah* by the GP. In my judgment, given this inconsistency it would not be appropriate to rely on the admission and grant summary judgment for Mr. Duffield on this matter. What Mr. Wynne was told about this matter by Mr. Duffield, and when he was told, are matters that can only be resolved at trial, where there will be the opportunity for the judge to hear the parties in person and to analyse their oral evidence in the context of the written materials that bear on the issue. It is not for me, on this application, to conduct a mini-trial of this matter.

142. Mr. Stevenson contends that, in any event, Mr. Wynne was aware from November 2013, on receipt of Professor Walley's report, that the GP had overprescribed *Rifinah*. I readily accept that from this date, and from reading this report, Mr. Wynne was aware of sufficient material that would have allowed him to reach that conclusion. Nevertheless, an allegation based on constructive knowledge is not made by Mr. Duffield in the Particulars of Claim. At paragraph 57, where the Claimant deals with the report from Professor Walley, reference is simply made to the conclusion that "the Claimant had been prescribed an excessively high dose of Rifinah", but no mention is made at this point in the pleading that the over-prescription was by the GP. On reading Professor Walley's report, it is clear that it was his view that the over-prescription was made by the GP. Nevertheless, that it is not the same as Mr. Wynne having actual knowledge that this was the case, as would be the situation if he had been told of this matter directly by Mr. Duffield. Indeed, for some time after Professor Walley's report, the correspondence suggests that Mr. Duffield did not endorse Professor Walley's view as to who had issued the over-prescription.

143. The same could also be said about the GP prescription records themselves that were shared with Mr. Wynne at some point (albeit the precise date on which they were shared is not clear). Mr. Wynne has said in evidence that he did not realise that these were records of prescriptions issued by Mr. Duffield's GP (as opposed to prescriptions issued to him by all prescribers), and it is not said by Mr. Duffield that he specifically made Mr. Wynne aware that the prescription records were of prescriptions issued by his GP.

144. In any event, even if Mr. Wynne had been aware that it was the GP who had overprescribed the *Rifinah*, this does not mean that the failure to issue proceedings against the GP protectively (so as to avoid limitation arguments) was necessarily a breach of the duty of care. It is in my judgment, at least arguable that a reasonably competent solicitor would not have issued against the GP in addition to claiming against the Trust. The claim against the GP was, as Mr. Carpenter QC contended, a sub-set of the claim against the Trust, as the over-prescription by the GP was plainly linked to (and presumably triggered by) the error in the letter from Dr. Yugambaranathan of September 19th 2001, and it was arguable that that claim was in time. Furthermore, there would potentially be additional adverse cost risks if the GP was sued, and the claim was subsequently discontinued.

145. In the circumstances, therefore, I do not grant summary judgment to the Claimant with respect to the management of the GP claim, whether as a matter of contract (for which no loss would need to be shown) or in tort.

146. In a mirror image to the Claimant's application for summary judgment, the Defendant has applied for summary judgment and/or to strike out the particulars of negligence that relate to the management of the GP claim. I do not accede to the Defendant's application either.

147. First, there is clearly a triable issue as to whether there was a breach of the duty of care such that Mr. Duffield will prevail on his breach of contract claim. Second, with respect to the tort claim, I adopt the same analysis as for the claim against the Trust. I cannot conclude that Mr. Duffield will be unable at trial to persuade the Court that he did suffer loss. Had the claim against the GP been progressed more expeditiously, and protective proceedings issued against the GP, it cannot be said that Mr. Duffield's claim would have inevitably been discontinued and abandoned. It is entirely possible that more expeditious management of the claim against the GP would have led to the instruction of different counsel who took a different view of the prospects of success to that taken by Dr. Punt. Mr. Carpenter QC acknowledged that it was "conceivable" that different counsel would reach a different view, and that was in my judgment the correct concession to have made. Dr. Punt's advice was not obviously right, nor was it obviously wrong. Accordingly, I cannot conclude that "but for" the alleged negligence Mr. Duffield suffered no loss.

148. In my judgment, therefore, these claims should proceed to trial.

(iv) Failing to advise as to Conflict of Interest: paragraph (k)

149. With respect to paragraph 118(k) of the Particulars of Claim – failing to advise the Claimant that the limitation deadline had been missed for a claim against the GP and that this created a potential conflict of interest between the Claimant and the Defendant – Mr. Duffield has not pleaded what would have happened had this advice been given to him. It is pleaded that Mr. Duffield was entitled to consider whether the advice to abandon both claims was influenced by the Defendant wishing to avoid criticism and a potential negligence claim; however, the pleaded case does not address the written advice of Dr. Punt which was negative as to the prospects of success at trial, and it is not suggested that Dr. Punt's advice was in any way influenced by the position of the Defendant and their potential conflict of interest on the issue of limitation.

150. The claim against the GP was no doubt out of time by June 2016, as Mr. Duffield was aware of the facts that would give rise to claim against the GP by June 2012 when he obtained the GP records, and it would have been very difficult to persuade a Court to exercise its discretion to extend time under section 33 of the Limitation Act 1980 in circumstances where Dr. Gandhi had died. I accept that there was an arguable case that Mr. Duffield should have been told by Mr. Wynne that the claim against the GP was out of time, and that this created a potential conflict of interest between him and Mr. Wynne. I only say "arguable", however, because as I have already explained I do not accept that Mr. Wynne had necessarily breached his duty of care towards Mr. Duffield in not issuing proceedings against the GP in time. Nevertheless, even if Mr. Wynne had breached his duty of care towards Mr. Duffield by failing to inform him of his own failure and of the conflict of interest, I cannot see how this caused Mr. Duffield any loss, and it is notable that Mr. Duffield has not sought to plead such a case.

151. In the circumstances, the claim in tort should be dismissed, but I do not dismiss the claim in contract. It is possible that Mr. Wynne breached the duty of care owed to Mr. Duffield by failing to inform him that the limitation deadline had been missed for a claim against the GP and that this created a potential conflict of interest between him and the Defendant. In a trial of the claim for breach of contract, however, there is no basis upon which Mr. Duffield could recover more than nominal damages in circumstances where no loss flowing from this breach is pleaded, and so any trial of the breach of contract claim cannot lead to an award of substantial damages.

(v) Failing to advise as to the potential value of the claim

152. With respect to paragraph 118(l) – *Advice on the value of the claim* – there is no pleaded case as to what would have happened had the value of the claim been advised to Mr. Duffield. The Claimant has not, therefore, pleaded his case on causation of any loss. In any event, the claim in tort is bound to fail because, irrespective of the value of the claim and what Mr. Duffield might have thought of that value, Dr. Punt's advice on the merits had to be reported to Temple, who would have cancelled the ATE policy and the Defendant would have terminated the CFA.

153. I do not dismiss the claim in contract, however, as it is possible that Mr. Wynne breached the duty of care owed to Mr. Duffield by failing to advise him at any point as to the value of his claim. In a trial of the claim for breach of contract, as there is no pleaded case on loss, Mr. Duffield could not recover more than nominal damages and will make an order to that effect.

Conclusion

154. In conclusion, therefore, I have decided that:

(i) the claims in tort and contract based on the particulars of negligence at paragraphs 118(a), (b), (c), (d), (e), (f) and (g) should be summarily dismissed. There is no real prospect that these grounds of claim (whether in contract or tort) will succeed at trial.

(ii) the claim in tort based on the particulars of negligence at paragraphs 118(k) and (l) should be struck out for failing to disclose a reasonable cause of action, as there is no pleaded case on loss.

(iii) the claim in contract based on the particulars of negligence at paragraphs 118(k) to (l) cannot (even if breach of the duty of care is established) result in anything other than nominal damages.

(iv) the claims in tort and contract based on the particulars of negligence at paragraphs 118(h), (i) and (j) should proceed to trial.