

OPINIONS
OF THE LORDS OF APPEAL
FOR JUDGMENT IN THE CAUSE

JD (FC) (Appellant)

v.

East Berkshire Community Health NHS Trust and others
(Respondents) and two other actions (FC)

ON
THURSDAY 21 APRIL 2005

The Appellate Committee comprised:

Lord Bingham of Cornhill
Lord Nicholls of Birkenhead
Lord Steyn
Lord Rodger of Earlsferry
Lord Brown of Eaton-under-Heywood

HOUSE OF LORDS

**OPINIONS OF THE LORDS OF APPEAL FOR JUDGMENT
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**JD (FC) (Appellant) v. East Berkshire Community Health NHS
Trust and others (Respondents) and two other actions (FC)**

[2005] UKHL 23

LORD BINGHAM OF CORNHILL

My Lords,

1. The question in this appeal is whether the parent of a minor child falsely and negligently said to have abused or harmed the child may recover common law damages for negligence against a doctor or social worker who, discharging professional functions, has made the false and negligent statement, if the suffering of psychiatric injury by the parent was a foreseeable result of making it and such injury has in fact been suffered by the parent.

2. On conventional analysis the answer to that question turns on whether the doctor or social worker owed any duty of care towards the parent, and the answer to that question essentially depends on whether, applying the familiar test laid down in *Caparo Industries plc v Dickman* [1990] 2 AC 605, 618, “the court considers it fair, just and reasonable that the law should impose a duty of a given scope upon the one party for the benefit of the other”.

3. The courts below have concluded that in such a situation no duty of care can be owed by the doctor or the social worker to the parent, that accordingly no claim may lie and that these claims brought by the parents must be dismissed with no evidence called and no detailed examination of the facts. In the second appeal there is also a claim by the child, but that has been treated differently. I understand that a majority of my noble and learned friends agree with this conclusion, for which there is considerable authority in the United Kingdom and abroad. But the law in this area has evolved very markedly over the last

decade. What appeared to be hard-edged rules precluding the possibility of any claim by parent or child have been eroded or restricted. And a series of decisions of the European Court of Human Rights has shown that application of an exclusionary rule in this sensitive area may lead to serious breaches of Convention rights for which domestic law affords no remedy and for which, at any rate arguably, the law of tort should afford a remedy if facts of sufficient gravity are shown.

4. I would not, for my part, strike out these claims but would allow them to go to trial. A judgment can then be made on the liability of the respective defendants on facts which have been fully explored. At present, we have only an agreed statement of what is, at this stage and for the purpose of legal argument, to be assumed. I take no account of additional factual allegations made by the appellants in their written case which, if true, may well be significant, but which have not been agreed. The facts which have been agreed are important and must be summarised.

The first appeal

5. JD, the claimant and first appellant, is a registered nurse and registered children's nurse now aged 50. She is the mother of M, who was born on 18 November 1988. M had a history of allergic reactions throughout his life, which were the subject of repeated medical scrutiny. He was treated at Wexham Park Hospital in Berkshire and Great Ormond Street in London. The diagnosis was correctly made that M suffered from multiple severe allergies.

6. In October 1994, at the request of his mother JD, M (aged 5) was referred by his general practitioner to Professor Southall, consultant paediatrician at the North Staffordshire Hospital. M was to be assessed for provision of a breathing monitor to enable him to sleep in his own bedroom. He was admitted to North Staffordshire Hospital from 9-15 December 1994 and assessed by Professor Southall, who formed the opinion that JD was suffering from Munchausen's Syndrome by Proxy, and that M's condition had been fabricated by her. She was unaware of this opinion, and the Professor did not see her or M after December 1994.

7. In March 1995 Professor Southall asked Professor Warner, a consultant paediatrician expert in allergic disorders, to see M at his

Burlesden Unit in Southampton without JD being present. She did not consent to this because the Unit had no intensive care or resuscitation facilities.

8. On 10 December 1996 Dr Whiting took over as the community paediatrician in Berkshire. She met JD once in December 1996 and contacted social services, suggesting that M was at risk from his mother JD and requesting urgent action. In early March 1997 Dr Whiting met Professor Southall, other doctors and a social worker. A handwritten minute was made.

9. On 18 March 1997 M was an in-patient at Great Ormond Street and JD chanced to see the handwritten minute, which contained the allegation that she was fabricating M's condition and harming him. She arranged to see a psychiatrist, who found nothing wrong with her. On 2 June 1997 a case conference was held at which it was decided to put M on the "At Risk Register". After this conference, M was assessed by Professor Warner, who confirmed both the extent and the severity of M's allergic problems. Child protection concerns were alleviated, and M was removed from the "At Risk Register" on 29 September 1997. JD claims to have suffered psychiatric injury as a result of the misdiagnosis of her and M's condition. She has not returned to nursing since this negligent misdiagnosis was made.

10. JD issued proceedings in March 2000 claiming damages for negligence. But her claim was struck out and dismissed by His Honour Judge Hale on the ground that public policy considerations militated strongly against the existence of any duty on the facts of the case: [2003] Lloyd's Rep Med 9, 12. The Court of Appeal (Lord Phillips of Worth Matravers MR, Hale and Latham LJ) dismissed JD's appeal against that decision in a judgment covering all three of the cases now before the House: [2003] EWCA Civ 1151, [2004] QB 558.

The second appeal

11. RK was born on 6 March 1989. She had the misfortune to suffer from Schamberg's disease, which is also known as progressive pigmented purpuric dermatitis or capillaritis and is manifested by the eruption of purple patches on the skin. Her father, the second appellant MAK, took her to her general practitioner in September 1997 with what was described as bruising on the legs. The marks disappeared after

treatment and no diagnosis of Schamberg's disease was made. On 15 March 1998 RK, now aged 9, hurt herself in the genital area while riding her bicycle. Two days later her swimming teacher expressed concern about the marks on her legs. She was taken to her general practitioner and was referred to Dr Wilson, a consultant paediatrician at Dewsbury District Hospital, to whom the father took her the same day.

12. Dr Wilson's provisional diagnosis was that the marks did not appear to be the result of skin disease but were suggestive of abuse. She informed social services and RK was examined by Dr Wilson and a police surgeon at the hospital. Her mother was told that RK had been sexually abused, and as a result her father and elder brother were told that they should not sleep at home when RK was released from hospital. In the hospital that evening, in front of other patients and visitors to the ward, the father was told that he was not allowed to see her.

13. RK remained in hospital until 27 March 1998 and the father did not visit her during that time. By 27 March a correct diagnosis of Schamberg's disease had been made. No further steps were taken by social services, and it was accepted by the Dewsbury Healthcare NHS Trust, the third respondent, in a letter of 15 April 1999, that there was no question of abuse.

14. The father and RK issued proceedings against the health authority and the local authority involved in the case, the third and fourth respondents, in March 2001, pleading several causes of action including negligence. The father claimed that he had suffered psychiatric injury and financial loss resulting from the third respondents' misdiagnosis and the steps taken by the fourth respondents. Following the decision of Judge Hale in JD's case, His Honour Judge Grenfell gave judgment for both defendants (now respondents) on the father's claims and on RK's claim against the local authority, but allowed her claim against the health authority to proceed: [2003] Lloyd's Rep Med 13, paras 15, 20, 26, 29, 31. The Court of Appeal upheld that decision in the composite judgment already referred to, save that it reinstated RK's claim against the local authority: para 109. She is accordingly free to prosecute her claims against the health authority and the local authority. There has been no appeal by the health authority or the local authority against the rulings of the judge and the Court of Appeal respectively on RK's claims against them.

The third appeal

15. MK was born on 24 July 1998. She suffered from brittle bone disease, or osteogenesis imperfecta. Aged 2 months, she was in the care of her grandmother and, when picked up from a sofa, started to scream and appeared to be in pain. Her parents and grandmother took her to the Royal Oldham Hospital, where she was seen in the Accident and Emergency Department and admitted. On admission, the medical personnel failed to take an accurate history from the parents and the grandmother: the notes referred to the mother rather than the grandmother having picked MK up, and to her having been “yanked” up, neither of which statements recorded what the family had said.

16. MK was diagnosed by the sixth respondent, Dr Blumenthal, a consultant paediatrician, as having an “inflicted injury”, namely a spiral fracture of the femur. The police and social services were informed. Thereafter, Dr Blumenthal did not pursue other investigations for osteogenesis imperfecta. This was despite two letters which he received. The first, dated 19 October 1998, was from the Solicitor to the Oldham Metropolitan Borough Council, writing to note that Dr Blumenthal had discounted a diagnosis of brittle bone disease on the basis of observation and asking whether any further tests could be conducted to indicate a cause for MK’s injuries other than inflicted injury. The second was a letter from the Council dated 8 December 1998, asking the doctor to address his mind to the possibility of a urine test to determine the existence of osteogenesis imperfecta.

17. An interim care order was made on 16 October 1998, and on 23 October 1998 MK was discharged into the care of her aunt. On 22 December 1998, in the Manchester County Court, the judge heard evidence and accepted the diagnosis of non-accidental injury. MK remained in the care of her aunt. The judge referred to the particular expertise of Dr Blumenthal as a specialist in child abuse cases and his conclusions that the mechanism by which the injury had been caused had been a violent twisting of the leg and that an inflicted injury was the only explanation of the fracture. This evidence led the judge in his judgment to describe both the mother and the grandmother as liars.

18. In March 1999, while in the care of her aunt, MK suffered bilateral femoral fractures. Further investigations were then carried out, including biochemical and metabolic tests on blood and urine. Experts in paediatric bone disease were of opinion that the history and injuries

were consistent with osteogenesis imperfecta. The interim care order was discharged on 17 June 1999, after 8 months. The separation from their firstborn child MK, and the misdiagnosis of non-accidental injury made and maintained, caused the parents a recognised psychiatric disorder, namely an adjustment disorder with a mixed anxiety and depressive reaction.

19. The father issued proceedings claiming damages for negligence on behalf of himself, the mother and MK. On 18 December 2002 Simon J granted the application of the fifth and sixth respondents, the health authority and the doctor, and dismissed the action: [2003] Lloyd's Rep Med 1. He concluded that it was not fair, just and reasonable to impose any duty of care to the parents in the circumstances and that MK had no valid claim: paras 21, 34. MK did not appeal against the dismissal of her claim and the Court of Appeal upheld Simon J's decision in relation to the parents: para 124 of its judgment.

The law

20. For purposes of these appeals it must be assumed that the cause of each child's medical condition was misdiagnosed and that such misdiagnosis was the result of a failure to exercise the standard of professional skill and care to be reasonably expected of a doctor or a social worker in the circumstances. No issue arises on the vicarious liability of the various employing authorities involved. It is to be assumed that each of the appellant parents suffered a recognised form of psychiatric injury as the result of the making or maintenance of the negligent misdiagnosis in each particular case. It was not contended before the House that such injury was not a foreseeable result of making or maintaining a negligent misdiagnosis in the circumstances. In none of the three cases has lack of proximity been relied on as an independent ground for dismissing the parents' claims in limine. The focus of debate is on whether it is fair, just and reasonable to impose a duty of care on health care and child protection professionals involved in cases such as these. But it is acknowledged – I think by both sides, and in my view rightly – that this question cannot be divorced from consideration of proximity.

21. There are, broadly speaking, three theoretical answers which may be given to the question whether doctors and social workers (to whom I shall refer compendiously as “healthcare professionals”) owe any common law duty of care other than to their employer, and if so what, in

a case of potential child abuse. The first is that they owe no such duty. The second is that they may on appropriate facts owe a duty to the child, but owe no duty to the parent. The third is that they may on appropriate facts owe a limited duty to the parent as well as the child. The appellants contend that this third answer is the correct one. The respondents, by not challenging the continuance of the child's claim against the health authority and the local authority in the second appeal, effectively contend for the second answer. The first answer was that given by a majority of the Court of Appeal and a unanimous House of Lords in *X (Minors) v Bedfordshire County Council* and *M (A Minor) v Newham London Borough Council* [1995] 2 AC 633. In para 83 of its judgment under appeal the Court of Appeal boldly, and in the view of some commentators impermissibly (see Wright: " 'Immunity' no more: Child abuse cases and public authority liability in negligence after *D v East Berkshire Community Health NHS Trust* " (2004) 20 PN 58, 63), held that that decision of the House, in its relation to claims by children, could not survive the Human Rights Act 1998, and before the House no party sought to maintain the full breadth of the decision. But much of the reasoning supporting the decision is relied on, and it has been followed in other jurisdictions. It is where examination of the authorities must begin.

22. In *X v Bedfordshire* itself, five child plaintiffs complained that they had been the victims of maltreatment and neglect which had been brought to the notice of the defendant council but on which, for a long time, the council had failed to act. The facts, only assumed when the strike-out application was heard in this country but established or accepted when the claimants took their complaint to Strasbourg, were very strong. An experienced and highly respected child psychiatrist described the children's experiences as "to put it bluntly, 'horrific'" and added that it was the worst case of neglect and emotional abuse that she had seen in her professional career: *Z v United Kingdom* (2001) 34 EHRR 97, para 40. It was accepted in Strasbourg that the neglect and abuse suffered by the four child applicants reached the threshold of inhuman and degrading treatment (para 74) and a violation of article 3 of the European Convention was found, arising from the failure of the system to protect the child applicants from serious, long-term neglect and abuse (paras 74-75). The Court awarded compensation amounting to £320,000, a substantial figure by Strasbourg standards. Yet the local authority's failure to intervene, which had permitted the abuse and neglect to continue, was held by the Court of Appeal and the House of Lords to afford the children no tortious remedy in negligence against the local authority in English law.

23. The facts of *M v Newham London Borough Council*, above, were less stark than in *X v Bedfordshire*, but they were disturbing enough. There was reason to believe that M, aged about 4, had been sexually abused. In the course of interview by healthcare professionals the child was thought to identify her mother's current partner as the abuser. In fact, it seems, the child identified a cousin who had earlier lived in the house and who had the same first name. The child was removed from the mother's care for a period of almost a year, during which time the mother was refused sight of the video and transcript made of the child's earlier interview. It was only when the video and transcript were seen by the mother's solicitors that it became clear that the healthcare professional had mistaken the identity of the alleged abuser. Both the mother and the child claimed damages for negligence against the employers of the healthcare professionals involved, but in the domestic proceedings the mother's claim was unanimously dismissed by the Court of Appeal and the House of Lords and the child's claim by a majority of the Court of Appeal and a unanimous House. At Strasbourg, both succeeded in establishing a violation of article 8, a finding based not on the decision to remove the child from the mother's care but on a failure to disclose to the mother immediately thereafter the matters relied on as showing that the child could not be returned safely to her care: if this had been done, it would have avoided the period of separation which followed and was said to have caused psychiatric disorder to both mother and child: *TP and KM v United Kingdom* (2001) 34 EHRR 42, paras 30, 80-83, 115-117. This was, again, a violation for which the English law of tort afforded no remedy.

24. In holding that it was not fair, just and reasonable to impose a duty of care on the healthcare professionals towards the claimants in *X v Bedfordshire* and *M v Newham* the House of Lords was strongly influenced by policy considerations identified in the opinion of Lord Browne-Wilkinson which, although much quoted, it is necessary for present purposes to repeat (pp 749-750):

“Is it, then, just and reasonable to superimpose a common law duty of care on the local authority in relation to the performance of its statutory duties to protect children? In my judgment it is not. Sir Thomas Bingham M.R. took the view, with which I agree, that the public policy consideration which has first claim on the loyalty of the law is that wrongs should be remedied and that very potent counter considerations are required to override that policy ante, p. 663C-D. However, in my judgment there are such considerations in this case.

First, in my judgment a common law duty of care would cut across the whole statutory system set up for the protection of children at risk. As a result of the ministerial directions contained in 'Working Together' the protection of such children is not the exclusive territory of the local authority's social services. The system is interdisciplinary, involving the participation of the police, educational bodies, doctors and others. At all stages the system involves joint discussions, joint recommendations and joint decisions. The key organisation is the Child Protection Conference, a multi-disciplinary body which decides whether to place the child on the Child Protection Register. This procedure by way of joint action takes place, not merely because it is good practice, but because it is required by guidance having statutory force binding on the local authority. The guidance is extremely detailed and extensive: the current edition of 'Working Together' runs to 126 pages. To introduce into such a system a common law duty of care enforceable against only one of the participant bodies would be manifestly unfair. To impose such liability on all the participant bodies would lead to almost impossible problems of disentangling as between the respective bodies the liability, both primary and by way of contribution, of each for reaching a decision found to be negligent.

Second, the task of the local authority and its servants in dealing with children at risk is extraordinarily delicate. Legislation requires the local authority to have regard not only to the physical wellbeing of the child but also to the advantages of not disrupting the child's family environment: see, for example, section 17 of the Act of 1989. In one of the child abuse cases, the local authority is blamed for removing the child precipitately; in the other, for failing to remove the children from their mother. As the Report of the Inquiry into Child Abuse in Cleveland 1987 (Cm. 412) said, at p. 244:

'It is a delicate and difficult line to tread between taking action too soon and not taking it soon enough. Social services whilst putting the needs of the child first must respect the rights of the parents; they also must work if possible with the parents for the benefit of the children. These parents themselves are often in need of help. Inevitably a degree of conflict develops between those objectives.'

Next, if a liability in damages were to be imposed, it might well be that local authorities would adopt a more cautious and defensive approach to their duties. For example, as the Cleveland Report makes clear, on occasions the speedy decision to remove the child is sometimes vital. If the authority is to be made liable in damages for a negligent decision to remove a child (such negligence lying in the failure properly first to investigate the allegations) there would be a substantial temptation to postpone making such a decision until further inquiries have been made in the hope of getting more concrete facts. Not only would the child in fact being abused be prejudiced by such delay; the increased workload inherent in making such investigations would reduce the time available to deal with other cases and other children.

The relationship between the social worker and the child's parents is frequently one of conflict, the parent wishing to retain care of the child, the social worker having to consider whether to remove it. This is fertile ground in which to breed ill feeling and litigation, often hopeless, the cost of which both in terms of money and human resources will be diverted from the performance of the social service for which they were provided. The spectre of vexatious and costly litigation is often urged as a reason for not imposing a legal duty. But the circumstances surrounding cases of child abuse make the risk a very high one which cannot be ignored.

If there were no other remedy for maladministration of the statutory system for the protection of children, it would provide substantial argument for imposing a duty of care. But the statutory complaints procedures contained in section 76 of the Act of 1980 and the much fuller procedures now available under the Act of 1989 provide a means to have grievances investigated, though not to recover compensation. Further, it was submitted (and not controverted) that the local authorities Ombudsman would have power to investigate cases such as these.

Finally, your Lordships' decision in the *Caparo* case [1990] 2 AC 605 lays down that, in deciding whether to develop novel categories of negligence the court should proceed incrementally and by analogy with decided categories. We were not referred to any category of case in which a duty of care has been held to exist which is in any way analogous to the present cases. Here, for the first time, the plaintiffs are seeking to erect a common law duty of care in relation to the administration of a statutory

social welfare scheme. Such a scheme is designed to protect weaker members of society (children) from harm done to them by others. The scheme involves the administrators in exercising discretions and powers which could not exist in the private sector and which in many cases bring them into conflict with those who, under the general law, are responsible for the child's welfare. To my mind, the nearest analogies are the cases where a common law duty of care has been sought to be imposed upon the police (in seeking to protect vulnerable members of society from wrongs done to them by others) or statutory regulators of financial dealings who are seeking to protect investors from dishonesty. In neither of those cases has it been thought appropriate to superimpose on the statutory regime a common law duty of care giving rise to a claim in damages for failure to protect the weak against the wrongdoer: see *Hill v Chief Constable of West Yorkshire* [1989] AC 53 and *Yuen Kun Yeu v Attorney-General of Hong Kong* [1988] AC 175. In the latter case, the Privy Council whilst not deciding the point said, at p. 198, that there was much force in the argument that if the regulators had been held liable in that case the principles leading to such liability 'would surely be equally applicable to a wide range of regulatory agencies, not only in the financial field, but also, for example, to the factory inspectorate and social workers, to name only a few.' In my judgment, the courts should proceed with great care before holding liable in negligence those who have been charged by Parliament with the task of protecting society from the wrongdoings of others."

These six considerations were very helpfully and succinctly summarised by May LJ in *S v Gloucestershire County Council* [2001] Fam 313, 329-330. It will be necessary to return to these considerations, some at least of which are relied on to support the decision under appeal.

25. But mention should first be made of the European Court decision in *Osman v United Kingdom* (1998) 29 EHRR 245. That case concerned the liability in negligence of the police towards a person claiming to have suffered as the result of a failure to apprehend a suspected criminal. To that extent its factual subject matter resembled that of *Hill v Chief Constable of West Yorkshire* [1989] AC 53, a decision which the domestic court had applied. The Court found a violation of article 6 of the Convention because, as it held in para 151 of

its judgment, the domestic court's application of the law had served to confer a blanket immunity on the police for their acts and omissions during the investigation and suppression of crime and therefore unjustifiably restricted a claimant's right to have his claim determined on the merits. See also the concurring judgment of Sir John Freeland at pp 321-322. This decision was the subject of compelling criticism by Lord Browne-Wilkinson in *Barrett v Enfield London Borough Council* [2001] 2 AC 550, 558-560. In that case, the claimant, who had spent his childhood in foster care, claimed damages against a local authority for decisions made and not made during that period. The judge's decision to strike out the claim had been upheld by the Court of Appeal but was unanimously reversed by the House. There are four points worthy of note for present purposes. First, it was accepted that a claim may lie against a local authority arising from child-care decisions in certain circumstances: see pp 557, 573, 575, 587-590. Secondly, the general undesirability of striking out claims arising in uncertain and developing areas of the law without full exploration of the facts was emphasised: pp 557-558, 575. This was a point made in *X v Bedfordshire* at pp 740-741 and is a point strongly echoed in later cases such as *Waters v Commissioner of Metropolitan Police* [2000] 1 WLR 1607, 1613; *W v Essex County Council* [2001] 2 AC 592, 598; *Phelps v Hillingdon London Borough Council* [2001] 2 AC 619, 659-660; and *L (A Child) and another v Reading Borough Council and another* [2001] EWCA Civ 346, [2001] 1 WLR 1575, 1587. Thirdly, the notion of an exclusionary rule conferring immunity on particular classes of defendant was rejected: pp 559, 570, 575. This rejection has been echoed with approval in later cases such as *Kent v Griffiths* [2001] QB 36, para 38; *S v Gloucestershire County Council*, above, p 338; and *E and Others v United Kingdom* (2002) 36 EHRR 519. Fourthly, it was not considered that the policy factors which had weighed with the House in *X v Bedfordshire* and *M v Newham* had the same weight where complaints related to acts and omissions after a child had been taken into care: [2001] 2 AC 550, 568, 575. The argument that imposition of a duty might lead to defensiveness and excessive caution was discounted, the remedies available to the claimant were not thought to be as efficacious as recognition of a common law duty of care and it was not accepted that imposition of a duty made no contribution to the maintenance of high standards: pp 568, 575. There was nothing to displace the general rule, recognised in *X v Bedfordshire* and *M v Newham* at pp 663 and 749, that the public policy consideration which had first claim on the loyalty of the law was that wrongs should be remedied: p 588.

26. In *S v Gloucestershire County Council* [2001] Fam 313 the plaintiff claimed damages in negligence against a local authority for abuse suffered by him during a placement with foster parents. The

Court of Appeal allowed the plaintiff's appeal against the striking out of his action while upholding the decision to strike out another action which was also the subject of appeal.

27. The claim in *W v Essex County Council* [2001] 2 AC 592 was made not only by children (or those who had been children when they suffered abuse) but also by parents. The parents had fostered a child on an assurance that he was not a known sexual abuser when, to the knowledge of the local authority, he was, and during his placement with the parents he sexually abused their children. Hooper J struck out the parents' claims but not those of the children: [1997] 2 FLR 535. The Court of Appeal (Stuart-Smith, Judge and Mantell LJ) unanimously upheld the judge's decision striking out the parents' claim and by a majority (Stuart-Smith LJ dissenting) upheld his decision on the children's claim, which was accordingly allowed to proceed: [1999] Fam 90. The House unanimously allowed the parents' appeal. It could not be said that the claim that there was a duty of care owed to the parents and a breach of that duty by the local authority was unarguable and it was inappropriate to strike out without investigation of the full facts known to, and the factors influencing the decision of, the local authority: p 598. In *A and B v Essex County Council* [2002] EWHC 2707 (QB), [2003] 1 FLR 615 a claim by adoptive parents for damages against a local authority came to trial on liability before Buckley J and succeeded. An appeal against his decision was dismissed, although on somewhat different grounds: *A and another v Essex County Council* [2003] EWCA Civ 1848, [2004] 1 WLR 1881.

28. *Phelps v Hillingdon London Borough Council* [2001] 2 AC 619 was one of four appeals heard together by an enlarged committee of the House. In each case the plaintiff complained of allegedly negligent decisions concerning his or her education made by the defendant local authorities. The procedural histories of the four cases were different, but in three of them the Court of Appeal had struck out the plaintiff's claim and in only one had it been allowed to proceed. The House unanimously dismissed the local authority's appeal in that last case but allowed the plaintiff's appeal in the other three. It was held to be clear in principle that a teacher or educational psychologist could in principle owe a duty of care to a child as well as an employing authority: pp 654, 665, 667, 670, 676. Valid claims in negligence were not to be excluded because claims which were without foundation or exaggerated might be made: pp 655, 665, 676. There was no reason to exclude the claims on grounds of public policy alone: pp 665, 672, 677. As my noble and learned friend Lord Nicholls of Birkenhead perceptively observed, "‘Never’ is an unattractive absolute in this context": p 667.

29. The plaintiffs in *L (A Child) and another v Reading Borough Council and another* [2001] 1 WLR 1575 were a daughter and her father. The proceedings arose out of a fabricated complaint made by the mother of the child to a local authority and police authority that he had sexually abused the child. The authorities had erroneously accepted the complaint as true, and the plaintiffs claimed damages for negligence against both authorities. The local authority did not apply to strike out either claim, but the police authority applied to strike out both claims against it. Goldring J struck out the father's claim against the police but allowed the child's negligence claim to proceed. The Court of Appeal allowed the father's appeal, holding that it was inappropriate to strike out on the basis of assumed facts: p 1587.

30. In the light of all this authority, coupled with *Z v United Kingdom* and *TP and KM v United Kingdom*, above, it could not now be plausibly argued that a common law duty of care may not be owed by a publicly-employed healthcare professional to a child with whom the professional is dealing. In *E and others v United Kingdom* (2002) 36 EHRR 519, a case in which four children complained of a local authority's failure to protect them from abuse by their stepfather, the European Court noted (in para 114 of its judgment):

“The Government submitted that it was not correct to assert that this House of Lords decision [in *X v Bedfordshire, M v Newham, et al*] prevented all claims in negligence against local authorities in the exercise of their child protection duties, and argued that it could not be regarded as beyond doubt that these applicants would have failed as, in the case of these applicants, the social services arguably were negligent in the way they approached operational, as well as policy, matters.”

Thus the respondents' reaction to the claims of the child RK in the second appeal is in no way surprising. But nor is it without significance. For in *X v Bedfordshire* itself the only claim was by the children, and in *M v Newham* the parent's claims were a very secondary issue: see my definition of the question at p 651, Peter Gibson LJ's reference to the “primary question” at p 676 and Staughton LJ's omission of any express reference to the parent save when holding, at p 676, that money would not be an appropriate remedy. In the House, the parent's entitlement was not separately addressed. Thus the policy considerations on which the decision of the House rested were primarily directed to justifying the exclusion of a class of claim which, it is accepted, can no longer be

excluded on application of a simple exclusionary rule. That conclusion makes it necessary to examine those considerations to ascertain how much force they retain if they no longer automatically exclude claims by children.

31. The first policy reason relied on for excluding a common law duty of care (pp 749-750) was that it would cut across the whole statutory and inter-disciplinary system for protecting children at risk and raise almost impossible problems of ascertaining and allocating responsibility. But this was not accepted as a reason for excluding liability in *Phelps v Hillingdon*, above, pp 655-656, 665-666, 674. In *Z v United Kingdom*, above, para 109, the European Court held that article 13 of the Convention required “a thorough and effective investigation capable of leading to the identification and punishment of those responsible”. If this consideration does not preclude a claim by the child it is hard to see why it should preclude a claim by the parent.

32. The second policy ground relied on was (p 750) that the task of a local authority and its servants in dealing with children at risk is extraordinarily delicate. There is a difficult line to tread between taking action too soon and not taking it soon enough. The truth of this may be readily accepted. It is however a standard function for any professional to assess what may be a fraught and difficult situation. That is not generally treated as a reason for not requiring the exercise of reasonable skill and care in the task. The professional is not required to be right, but only to be reasonably skilful and careful. If such skill and care are required in relation to the child, there is no reason why this consideration should preclude a duty to the parent.

33. The third policy reason relied on to deny a duty of care (p 750) was that local authorities might adopt a more cautious and defensive approach. As already noted, this consideration was discounted in *Barrett v Enfield*, above, at p 568, as it had been by the Court of Appeal in that case: [1998] QB 367, 380. It was discounted by Lord Clyde in *Phelps v Hillingdon*, above, at p 672. A similar argument, based on very different facts, was rejected in *Spring v Guardian Assurance plc* [1995] 2 AC 296, 326, 336. It is hard to see how, in the present context, imposition of a duty of care towards parents could encourage healthcare professionals either to overlook signs of abuse which they should recognise or to draw inferences of abuse which the evidence did not justify. But it could help to instil a due sense of professional responsibility, and I see no reason for distinguishing between the child and the parent. To describe awareness of a legal duty as having an

“insidious effect” on the mind of a potential defendant is to undermine the foundation of the law of professional negligence.

34. The next policy consideration relied on (pp 750-751) was the risk of conflict between social worker and parent. This is perhaps the most crucial point in this appeal, and I must address it in some detail below.

35. The fifth policy reason relied on (p 751) was that other remedies were available to the child under the legislation. The House did not explain how the grossly abused children in *X v Bedfordshire* were to avail themselves of the available procedures, which could not in any event yield any compensation to child or parent. But this point need not be pursued, since in *Z v United Kingdom*, above, Her Majesty’s Government accepted that in the particular circumstances of the case the available remedies were insufficient alone or cumulatively to satisfy the requirement of article 13 of the Convention: para 107. In *TP and KM v United Kingdom*, above, the Court similarly found a lack of suitable remedies: paras 107-110. Both Lord Slynn in *Barrett v Enfield*, above, p 568, and Lord Clyde in *Phelps v Hillingdon*, above, p 672, recognised imposition of a duty of care and a claim for common law damages as likely to be more efficacious than other remedies and as perhaps the only efficacious remedy.

36. The last policy consideration relied on in *X v Bedfordshire* was the accepted principle, adopted by the House in *Caparo v Dickman*, above, p 618, based on the opinion of Brennan J in *Sutherland Shire Council v Heyman* (1985) 157 CLR 424, 481, that

“the law should develop novel categories of negligence incrementally and by analogy with established categories, rather than by a massive extension of a prima facie duty of care restrained only by indefinable ‘considerations which ought to negative, or to reduce or limit the scope of the duty or the class of person to whom it is owed’.”

In *X v Bedfordshire* it was plainly seen as an unjustifiable extension of existing principle to impose a duty of care on a healthcare professional towards a child or a parent. But it is now accepted that a duty may be owed to a child, and in certain decided cases a duty to the parent has been accepted as arguable. To accept as arguable a claim by parents on facts such as give rise to these appeals involves no massive extension of

a prima facie duty. It is not unimportant, for it accommodates what Lord Goff of Chieveley in *White v Jones* [1995] 2 AC 207, 260, called “the strong impulse for practical justice”. But in legal terms it is a small, analogical, incremental development.

37. It is important to be clear on the scope of the duty which the appellants seek to be allowed to try and establish as owed by the healthcare professionals. It is a duty not to cause harm to a parent foreseeably at risk of suffering harm by failing to exercise reasonable and proper care in the making of a diagnosis of child abuse. This is in substance, the appellants contend, the same duty as the healthcare professionals already owe to the child. The duty to the child is breached if signs of abuse are overlooked which a careful and thorough examination would identify, and the obvious risk then is that abuse which would otherwise be stopped is allowed to continue. But this would be a breach of the duty if owed to a normal parent, whose interest would be the same. It would be no different if a parent were the abuser, since the duty of the healthcare professional is to serve the lawful and not the criminal interests of the parent; in any event, an undetected abuser could never be heard to complain. If a diagnosis of child abuse were made when the evidence did not warrant it (which is the factual premise of all three appeals) there would be a breach of duty to the child, with separation or disruption of the family as possible or likely consequences. But this would be a breach of the duty owed to the parents also, and the consequences are not suffered by the child alone. In *Hungerford v Jones* 722 A. 2d 478, 480 (1998) the US District Court for New Hampshire referred to “the potentially devastating consequences stemming from misdiagnosis”, and Gray J in the Supreme Court of South Australia spoke to similar effect in *CLT v Connon* [2000] SASC 223, (2000) 77 SASR 449, 459:

“Devastating consequences can follow an incorrect finding that a child has been sexually abused. Those consequences flow not only to the person against whom the findings are made, but also to the child and the family.”

The appellants do not argue for a duty to serve any interest of the parents save their interest in a skilful and careful diagnosis of the medical condition of their child.

38. In contending that a healthcare professional cannot, even arguably, owe to a parent the duty postulated the respondents rely, first,

on the disturbing prevalence of child abuse and on the high importance attached by successive governments and society as a whole to early identification of abuse and effective protection of children against it. This concern is evidenced by primary and subordinate legislation, ministerial guidance and independent reports. Maria Colwell, Janice Beckford and Victoria Climbié are perhaps the most horrifying examples of the tragedies which can occur when signs of abuse are not recognised and addressed when they should be. It is important that signs which, viewed in isolation, may be very inconclusive are observed and noted and information shared with other appropriate bodies engaged in child protection. And it may be necessary to take action which is deeply unwelcome to the parents and strongly resisted by them. I summarise this point very briefly, not because it is unimportant but because it is uncontroversial. Nothing in the appellants' argument or in my opinion throws any doubt on the supreme importance of identifying child abuse and protecting children against it.

39. In their valuable Report on the Victoria Climbié Inquiry (CM 5730), January 2003, Lord Laming and his colleagues emphasised the importance of communication and sharing of information between healthcare professionals, even where the evidence justified no more than a suspicion. The duty for which the appellants contend does not conflict with or undermine this desirable practice. The third appeal provides a good illustration. The appellants in that appeal accept that non-accidental injury was one explanation of the child's condition which a competent healthcare professional would have entertained, and indeed the most likely explanation (even if the history had been accurately recorded). Thus they do not complain that this differential diagnosis was entertained. What they complain of is the absolute terms of the diagnosis and its firm acceptance, upon which action was based, even when ample time had passed during which further investigation could and should have been made which would have revealed its unreliability. The same complaint lies at the heart of the other two appeals. Thus it is not the formation or communication of a suspicion which is complained of, but a negligent failure to investigate, test, explore, check and verify. It is clear that emergencies may arise in which it may be necessary to take action to remove a child from the care of a parent even though the evidence to make a firm diagnosis is lacking. The European Court judged *TP and KM v United Kingdom*, above, to be such a case. What the healthcare professionals are required to do is exercise reasonable skill and care in taking an accurate history and then to form such professional opinion as, subject to further investigation, may be appropriate. My noble and learned friend Lord Brown of Eaton-under-Heywood makes reference to evidence submitted 18 months after the Court of Appeal judgment by Professor Sir Alan Craft and Miss Mary

Marsh. But it is plain that what they respectively call “The easy option” and “the line of least resistance” is as much a breach of the professional duty admittedly owed to the child as it would be of a duty owed to the parent. The difference is that a child is much less likely to complain.

40. The respondents also draw attention to the difficulty of recruiting and retaining skilled paediatricians and social workers to work in the child protection field. The problem would be exacerbated, it is said, if they were to be held to owe a duty of care to parents. I cannot for my part accept that this problem – if it exists, as it may – would be exacerbated by imposition of a responsibility which, in most contexts, is a badge of professional status. But I would not in any event accept that the courts should calibrate duties of care so as to regulate shortages in the professional labour market.

41. Thirdly, the respondents submit that for healthcare professionals working in this field the welfare of the child is paramount and any duty owed to the parent would conflict with it. The first of these points is correct and not open to doubt. The second point is an important one and, if correct, a strong and even conclusive argument against imposition of such a duty. It was the possibility or likelihood of conflict which led me, in *M v Newham*, above, pp 665, 667, to dismiss the mother’s claims against the psychiatrist and the local authority, although my observations were directed to action rather than diagnosis. The Court of Appeal found a risk of conflict in the present cases also: see [2004] QB 558, paras 95-96, 112 and 123-124 of the judgment. Some foreign courts have taken the same view: eg, *Bird v WCW* 868 SW 2d 767 (1994). The appellants advance two main answers to this contention. The first is that on the duty for which they contend, limited to diagnosis, there can be no conflict, for reasons summarised in para 37 above.

42. The appellants’ second main answer is to criticise, as a general proposition pertaining to diagnosis, the supposed dichotomy between the child and the parents. Domestic authority, ministerial guidance and Strasbourg authority all encourage, they argue, a general practice which, subject to necessary exceptions, envisages co-operative partnership between healthcare professionals and parents in the interests of the child, and a sharing of information, as early as may be, by healthcare professionals with parents. In *Re L (Care: Assessment: Fair Trial)* [2002] EWHC 1379 (Fam), [2002] 2 FLR 730, para 151, Munby J emphasised the need, in the interests not merely of the parent but also of the child, of a transparently fair and open procedure at all stages of the

care process, including the making of documents openly available to parents. In “Working Together”, ministerial guidance issued in 1991, the possibility of conflict with parents was recognised, and it was clearly stated that in cases of conflict the interests of the child must prevail: eg, paras 4.28, 6.12. But the document laid heavy emphasis on involving the parents (para 1.1), on partnership with the parents (paras 1.4, 5.4), on the wishes of the parents (para 1.6), on the need for a high degree of co-operation with parents (para 1.8). In “Working Together to Safeguard Children”, ministerial guidance issued in 1999, professionals were encouraged to do more to work in partnership with parents (para 2.25) and to involve parents as fully as practicable (para 2.26).

43. A long stream of Strasbourg authority is to somewhat similar effect. In *W v United Kingdom* (1987) 10 EHRR 29 the Court ruled that a local authority must, in reaching decisions on children in care, take account of the views and interests of the natural parents, which called for a degree of protection: paras 63-64. The same view was taken in *B v United Kingdom* (1987) 10 EHRR 87. In *McMichael v United Kingdom* (1995) 20 EHRR 205, both the Commission (pp 227-228, paras 102-106) and the Court (p 241, paras 92-93) found a breach of article 8 because the parents had not been adequately consulted and informed. The Court repeated (para 86) its well-established case law that “the mutual enjoyment by parent and child of each other’s company constitutes a fundamental element of family life.” In *Elsholz v Germany* (2000) 34 EHRR 1412 a violation of article 8 was found when access to his child was denied to an innocent father. In *TP and KM v United Kingdom*, above, the Court did not criticise the emergency action to remove the child from the mother’s care but found that failure to disclose the transcript and video did not afford due respect to the parents’ interests safeguarded by article 8: paras 74, 82-83. Many of the same points were repeated by the Court in *P, C and S v United Kingdom* (2002) 35 EHRR 1075, paras 113, 119, 120 and again in *Venema v Netherlands* (2002) 39 EHRR 102, paras 71, 91-93.

44. It is in my opinion clear from all this authority that far from presuming a conflict between the interests of child and parent the law generally presumes that they are consonant with each other or at any rate, if not consonant, not so dissonant that healthcare professionals should proceed without fully informing and consulting the parents. There are of course occasions when emergency action must be taken without informing the parents, and when information must for a time be withheld. But there is no reason why the occasional need for healthcare professionals to act in this way should displace a general rule that they

should have close regard to the interests of the parents as people with, in the ordinary way, the closest concern for the welfare of their children.

45. The respondents relied on the statement of Lord Diplock in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871, 890, that

“a doctor’s duty of care, whether he be general practitioner or consulting surgeon or physician is owed to that patient and none other, idiosyncrasies and all.”

In *M v Newham*, above, pp 673-674, Staughton LJ concluded that the child was not in law and for all purposes the patient of the psychiatrist, and observed:

“The child was no more the patient than an applicant for life insurance who is examined by the company’s doctor, or the errant motorist who is deprived of a small quantity of blood by the police surgeon.”

Peter Gibson LJ, at p 684, and Lord Browne-Wilkinson, speaking for the House, at pp 752-753, adopted a similar line of reasoning. It has been applied by the Court of Appeal in cases such as *Powell v Boladz* [1998] Lloyd’s Rep Med 116 and *Kapfunde v Abbey National plc and Daniel* [1999] ICR 1.

46. Lord Diplock’s statement was, however, an obiter dictum, and one with which no other member of the House expressed agreement. The responsibility of other professionals has not been so restricted. One may instance *Ross v Caunters* [1980] Ch 297, followed in New Zealand in *Gartside v Sheffield, Young & Ellis* [1983] NZLR 37 even before its approval by the House in *White v Jones* [1995] 2 AC 207. Or *Smith v Eric S Bush* [1990] 1 AC 831. Or *Spring v Guardian Assurance plc*, above. Even in the medical sphere the law is much less clear than Lord Diplock’s dictum might suggest: see Grubb, *Principles of Medical Law*, 2nd ed (2004), chap 5, para 5.48. In *Everett v Griffiths*, Atkin LJ in the Court of Appeal ([1920] 3 KB 163, 216-217) and Viscount Haldane and Viscount Cave in the House of Lords ([1921] 1 AC 631, 657-658, 680) were inclined to the view that a workhouse doctor owed a duty of care to a person whom he certified to be insane. In *Re N* [1999] Lloyd’s Rep

Med 257, 263, Clarke LJ thought it at least arguable that where a forensic medical examiner carries out an examination and discovers that the person being examined has a serious condition which needs immediate treatment, a duty is owed to the examinee to disclose those facts. In some American jurisdictions it has been accepted that a doctor may owe a duty to a person who is not his patient: see, for example, *Tarasoff v Regents of the University of California* 551 P 2d 334 (1976) (California), *Wilkinson v Balsam* 885 F Supp 651 (1995) (Vermont), *Hungerford v Jones*, above, (New Hampshire), *Sawyer v Midelfort and Lausted* (Case No 97-1969, 29 June 1999, Supreme Court of Wisconsin), *Stanley v McCarver* 430 Ariz Adv Rep 3, 92 P 3d 849 (2004) (Arizona). The High Court of Australia, while rejecting an argument to the same effect as the appellants', has accepted that a medical practitioner who examines and reports on the condition of an individual may owe a duty to more than one person: *Sullivan v Moody* (2001) 207 CLR 562, para 60. In the present case acceptance of that proposition is implicit in acceptance of a potential duty to the child. So the question is whether, in diagnosing the child's condition in a case of possible abuse, the position of the child is so different from that of the parent that a duty may sensibly be owed to the one but not to the other.

47. The appellants, as parents, had parental responsibility for their respective children under section 2(1) of the Children Act 1989, and so were invested, by section 3(1), with all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child. Parental powers of course exist and must be exercised for the benefit of the child (*Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, 170) but in most cases the best judges of a child's welfare are the parents (p 173) and it is ordinarily for the parent to give or withhold consent to medical treatment (pp 184, 200). The parent's decision should ordinarily be respected: see *In re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147, 178). The younger the child, of course, the greater the role of the parent: with children of the ages of those involved in these cases, the parents inevitably make all the significant decisions in the children's lives. In the present cases, unlike *M v Newham*, above, the first approach to the healthcare professionals was made by the parent. Had the approach been made pursuant to contract, there could, I think, be no doubt that the healthcare professional would owe the parent a duty to exercise reasonable skill and care in diagnosing the child's condition. Does the payment of a fee make all the difference? Lord Devlin surely answered this question in *Hedley Byrne & Co Ltd v Heller & Partners Ltd* [1964] AC 465, 517:

“If irrespective of contract, a doctor negligently advises a patient that he can safely pursue his occupation and he cannot and the patient’s health suffers and he loses his livelihood, the patient has a remedy. But if the doctor negligently advises him that he cannot safely pursue his occupation when in fact he can and he loses his livelihood, there is said to be no remedy. Unless, of course, the patient was a private patient and the doctor accepted half a guinea for his trouble: then the patient can recover all. I am bound to say, my Lords, that I think this to be nonsense. It is not the sort of nonsense that can arise even in the best system of law out of the need to draw nice distinctions between borderline cases. It arises, if it is the law, simply out of a refusal to make sense. The line is not drawn on any intelligible principle. It just happens to be the line which those who have been driven from the extreme assertion that negligent statements in the absence of contractual or fiduciary duty give no cause of action have in the course of their retreat so far reached.”

If one thinks in terms of proximity, it is hard to think of a relationship very much more proximate than that between parent and doctor when the parent, concerned about the medical condition of a child, takes the child to see the doctor and seeks the doctor’s help. The relationship of the social worker with the parent is different but, as shown in para 42 above, good practice requires that that relationship should be close and co-operative.

48. There is little general guidance to be gained from American authority on the main issue before the House, since in most states those reporting child abuse enjoy immunity from suit, a provision which no doubt reflects the importance attached to child protection but might also reflect some distrust of civil juries. I should however refer to New Zealand authority. In *Attorney-General v Prince and Gardner* [1998] 1 NZLR 262 claims in negligence were made by the natural mother of a child who had been adopted, and also by the child (now adult), complaining of the process followed in the adoption and also of failure to investigate a complaint made about his treatment when the child was still a child. The Court of Appeal of New Zealand struck out the first of these claims as incompatible with the adoption regime laid down by statute in New Zealand, but it also, by a majority, allowed both the claims under the second head to proceed to trial. This case was considered by the Privy Council in *B and others v Attorney General of New Zealand* [2003] UKPC 61, [2003] 4 All ER 833. The claim in that

case was made by a father and his two daughters, and was based on the allegedly negligent investigation of a complaint that the father had sexually abused the daughters. At first instance the judge (following *X v Bedfordshire* and *M v Newham*, above) had struck out the proceedings on the ground that no duty was owed to father or daughters and so the claims were bound to fail. The Court of Appeal of New Zealand had upheld this decision. The Privy Council allowed the appeal by the daughters but dismissed that of the father, holding that a duty was owed to them but not to him. In delivering the judgment of the Board, my noble and learned friend Lord Nicholls of Birkenhead said, in para 30:

“30. To whom is the duty of care owed? Clearly the duty is owed to the child or young person in respect of whom the statutory duty to arrange for a prompt inquiry exists in the particular case. In the present case that is [daughter 1] as much as [daughter 2]. If [daughter 2’s] abuse allegation was well founded [daughter 1] also was at risk. But their Lordships consider no common law duty of care was owed to the father. He stands in a very different position. He was the alleged perpetrator of the abuse. In an inquiry into an abuse allegation the interests of the alleged perpetrator and of the children as the alleged victims are poles apart. Those conducting the inquiry must act in good faith throughout. But to impose a common law duty of care on the department and the individual professionals in favour of the alleged victims or potential victims and, at one and the same time, in favour of the alleged perpetrator would not be satisfactory. Moreover, a duty of care in favour of the alleged perpetrator would lack the juridical basis on which the existence of a common law duty of care was largely founded in *Prince’s* case. The decision in *Prince’s* case rests heavily on the feature that the duty imposed on the Director-General by s 5(2)(a) of the 1974 Act is for the benefit of the particular child. Self-evidently this statutory duty was not imposed for the benefit of alleged perpetrators of abuse. To utilise the existence of this statutory duty as the foundation of a common law duty in favour of perpetrators would be to travel far outside the rationale in *Prince’s* case.”

This passage was strongly relied on by the respondents, to whom it is clearly helpful. But there are factual differences between that case and the present cases. The parent had not himself initiated the request for

medical advice. There had, it seems, been sexual abuse. The father had not been exonerated from suspicion. No emphasis appears to have been laid on the duty to make disclosure to and cooperate with parents. And there was no discussion of any rights deriving from the New Zealand Bill of Rights Act 1990, since it contains no provision equivalent to article 8 of the European Convention. Since it was the Human Rights Act which led the Court of Appeal in the present case (para 83) to regard *X v Bedfordshire*, above, as effectively overruled in relation to claims by children, this is a significant distinction. After the New Zealand Court of Appeal's decision in *Prince* but before its decision in *B*, a High Court master in Christchurch refused to strike out a claim in negligence by a father against a psychotherapist who had erroneously concluded that he had sexually abused his daughter, holding that a duty of care might, depending on the evidence, be established and that the matter should be resolved at trial: *N v D* [1999] NZFLR 560.

49. It would seem clear that the appellants' claim would not be summarily dismissed in France, where recovery depends on showing gross fault: see Markesinis, Auby, Coester-Waltjen and Deakin, *Tortious Liability of Statutory Bodies* (1999), pp 15-20; Fairgrieve, "Child Welfare and State Liability in France", in *Child Abuse Tort Claims against Public Bodies: A Comparative Law View*, ed Fairgrieve and Green (2004), pp 179-197, Fairgrieve, "Beyond Illegality: Liability for Fault in English and French Law", in *State Liability in Tort* (2003), chap 4. Nor would they be summarily dismissed in Germany where, it is said, some of the policy considerations which influenced the House in *X v Bedfordshire* were considered by those who framed §839 of the BGB and were rejected many years ago: see Markesinis *et al.*, *op. cit.*, 58-71; Martina Künnecke, "National Report on Germany", in Fairgrieve and Green, *op. cit.*, pp 199-207. Yet in neither of those countries have the courts been flooded with claims. If, as some respected academic authorities suggested, *Barrett v Enfield*, above, shifted the emphasis of the English courts from consideration of duty to consideration of breach (see Craig and Fairgrieve, "*Barrett*, Negligence and Discretionary Powers" [1999] PL 626, Fairgrieve, *State Liability in Tort* (2003), p 84, para 2.1.2.7), I would for my part regard that shift as welcome, since the concept of duty has proved itself a somewhat blunt instrument for dividing claims which ought reasonably to lead to recovery from claims which ought not. But I should make it plain that if breach rather than duty were to be the touchstone of recovery, no breach could be proved without showing a very clear departure from ordinary standards of skill and care. It should be no easier to succeed here than in France or Germany.

50. In dismissing a claim by a father against a health authority for negligent treatment of his daughter by a psychiatrist in *Fairlie v Perth and Kinross Healthcare NHS Trust* 2004 SLT 1200, para 36, Lord Kingarth suggested that a claim might perhaps have been pleaded under article 8 of the European Convention. Since the pursuer's claim was in effect for loss of reputation (paras 34-35), the claim in negligence was bound to fail even if the judge had not held, as he did in para 30 of his judgment, that no duty of care was owed to the father. But the question does arise whether the law of tort should evolve, analogically and incrementally, so as to fashion appropriate remedies to contemporary problems or whether it should remain essentially static, making only such changes as are forced upon it, leaving difficult and, in human terms, very important problems to be swept up by the Convention. I prefer evolution.

51. For all these reasons I would allow these appeals.

LORD NICHOLLS OF BIRKENHEAD

My Lords,

52. It must be every parent's nightmare to be suspected of deliberately injuring his or her own child. In the three cases before your Lordships' House doctors suspected a child had been the subject of non-accidental injury by a parent or, in one case, false reporting carrying a future risk of non-accidental injury. In each case after further investigation it turned out this was not so. In each case the parent then brought proceedings against the hospital trust and, in one instance, the doctor personally claiming damages for negligence in the clinical investigation, diagnosis and reporting of the child's condition.

53. The primary question before the House is whether doctors and, vicariously or directly, health trusts are liable in damages to a parent in such a case. Hand-in-hand with this is a parallel question concerning the liability of a local authority in respect of its investigation of suspected child abuse.

54. None of these cases has proceeded beyond the pleadings stage. In each case the outcome at first instance of preliminary issues of law or

the equivalent was that the parent's claim was bound to fail. So a trial would serve no useful purpose. The parents appealed from these decisions. The appeals were dismissed by the Court of Appeal, comprising Lord Phillips of Worth Matravers MR, Hale and Latham LJ: [2004] QB 558. The parents have now appealed to your Lordships' House.

55. The three cases raise an important issue of principle. But the facts alleged by the claimant parents exemplify how this problem may arise in practice. So a brief summary is called for. For present purposes it is to be assumed in favour of the claimants that at trial they might be able to prove the facts they have alleged, but in each case negligence is denied by the defendants.

The East Berkshire case

56. In the East Berkshire case the claimant JD is the mother of a boy M born in November 1988. She is suing two NHS trusts, East Berkshire Community Health NHS Trust and North Staffordshire Hospital NHS Trust. She claims that in December 1994 doctors employed by these Trusts negligently misdiagnosed her as suffering from Munchausen's syndrome by proxy and that they negligently maintained this misdiagnosis until September 1997. In consequence she suffered a reaction of acute anxiety and depression. She claims damages for psychiatric injury.

57. The boy M has had a history of allergic reactions throughout his life. These have been the subject of repeated medical scrutiny. He suffered from asthma attacks and as a result slept in the same bedroom as his mother. He was admitted to the North Staffordshire hospital in December 1994 to see if it would be possible to provide a monitor for his breathing so he could sleep in his own bedroom. The opinion of Professor Southall, a consultant paediatrician at the hospital, was that the mother was suffering from Munchausen's syndrome by proxy and that she had fabricated M's condition.

58. The consultant community paediatrician for Berkshire responsible for M did not share this view. At this stage the social services were not involved. In December 1996 Dr Whiting took over responsibility for the care of M. Dr Whiting considered the boy might be at risk from his mother. In March 1997 the mother chanced to learn,

for the first time, of concern that she might be fabricating M's condition. At her request her general practitioner referred her to a psychiatrist who found nothing wrong with her. Between March and June 1997 there was much discussion between doctors and the social services, culminating in a case conference in June 1997. A decision was made to put M on the 'at risk' register. M was also referred to an expert on allergic conditions. He concluded that M was indeed suffering from extensive and severe allergies. M was removed from the 'at risk' register in September 1997.

59. Thus in this case the mother was not separated from her child. But for a period of about six months she knew she was under suspicion. Presumably for part of that time she also knew the child was on the 'at risk' register.

60. On 6 September 2002 Judge Hale, sitting in the Chester County Court, held on a preliminary issue that neither East Berkshire Community Health NHS Trust nor North Staffordshire Hospital NHS Trust, nor any of the other defendants then being sued, owed a duty of care to the mother: [2003] Lloyd's Rep Med 9.

The Dewsbury case

61. The claimants in the Dewsbury case are a father M A K and his daughter R. They have brought proceedings against Dewsbury Healthcare NHS Trust and Kirklees Metropolitan Council. The council is responsible for the provision of social services in the Dewsbury area. M A K and R claim damages in negligence for psychiatric injury and financial loss resulting from a clinical misdiagnosis that R had been subject to sexual abuse and from the consequential investigatory steps taken by the social services.

62. At the relevant time R was nine years old. She suffered from Schamberg's disease, which produces discoloured patches on the skin. In March 1998 she hurt herself in the genital area while riding her bicycle. On 17 March her mother took her to a general practitioner who referred her to Dr Wilson, a consultant paediatrician at Dewsbury District Hospital. Her father took R to see Dr Wilson on the same day. Dr Wilson's provisional diagnosis was that the marks on R's legs were suggestive of abuse. She informed the social services. R was admitted

to hospital at once and examined further. Dr Wilson concluded R had been sexually abused. Her mother was so informed.

63. The father and his son, R's elder brother, were told they should not sleep at home when R was released from hospital. In the hospital, in front of other patients and visitors to the ward, M A K was told he was not allowed to see R. R remained in hospital for ten days. By 27 March the correct diagnosis of Schamberg's disease was made. The social services took no further steps, and it was accepted there was no question of abuse.

64. Thus in this case the father was under suspicion for a period of days while his daughter was in hospital. During that time he was unable to see her.

65. Judge Grenfell, sitting in the Leeds County Court, dismissed the father's claim against both defendants: [2003] Lloyd's Rep Med 13. As to the child's claim, the judge held R has an arguable claim for clinical negligence against Dr Wilson and, accordingly, against Dewsbury Healthcare NHS Trust. So the judge permitted that claim to proceed. The Trust did not appeal against that order. The judge dismissed R's claim against Kirklees Metropolitan Council. R appealed against that order, and the Court of Appeal allowed the child's appeal. The local authority has not appealed against that order. So the claim by R is proceeding against both defendants

The Oldham case

66. The claimants in the Oldham case are RK and his wife AK. They are the parents of a girl M born in July 1998. On 26 September 1998, when she was two months old and in the care of her grandmother, M started to scream when her grandmother lifted her from a settee. Her parents and grandmother took her to the Royal Oldham Hospital. On admission the medical staff failed to take an accurate history from them and the grandmother. Dr Blumenthal, a consultant paediatrician, diagnosed the baby as having an 'inflicted injury', a spiral fracture of the femur. The police and social services were informed. Dr Blumenthal did not investigate further the possibility of a diagnosis of osteogenesis imperfecta ('brittle bones').

67. Oldham Metropolitan Borough Council applied for an interim care order. The order was made on 16 October 1998. On 23 October M was discharged from hospital into the care of an aunt, with supervised access for the parents. At a hearing on 23 December the court decided M's injuries were non-accidental and care was given to the aunt. In March 1999 M sustained further fractures. More tests were carried out, and the revised medical opinion was that the history and injuries were consistent with brittle bone disease. On 17 June 1999, nearly nine months after being admitted to hospital, M was returned to the care of her parents. It is now accepted that the initial diagnosis of non-accidental injury was wrong.

68. Thus in this case the mother was separated from her young baby for a period of eight months, being permitted only supervised access.

69. The parents claim damages in negligence from Oldham NHS Trust and Dr Blumenthal for psychiatric injury resulting from their separation from M. On the hearing of preliminary issues Simon J held that neither defendant owed a duty of care to the parents: [2003] Lloyd's Rep Med 1. The daughter M was herself a claimant in the proceedings, but Simon J held that the evidence produced for the preliminary issues disclosed no injury for which the law provided a remedy: M had suffered no physical harm or recognisable psychiatric disorder. She did not appeal against that part of the judge's order.

Countervailing interests

70. There are two cardinal features in these cases. One feature is that a parent was suspected of having deliberately harmed his or her own child or having fabricated the child's medical condition. The other feature, which is to be assumed, is that the ensuing investigation by the doctors was conducted negligently. In consequence, the suspected parent's family life was disrupted, to greater or lesser extent, and the suspected parent suffered psychiatric injury.

71. It is the combination of these features which creates the difficult problem now before the House. In the ordinary course the interests of parent and child are congruent. This is not so where a parent wilfully harms his child. Then the parent is knowingly acting directly contrary to his parental responsibilities and to the best interests of his child. So the liability of doctors and social workers in these cases calls into

consideration two countervailing interests, each of high social importance: the need to safeguard children from abuse by their own parents, and the need to protect parents from unnecessary interference with their family life.

72. The first of these interests involves protection of children as the victims of crime. Child abuse is criminal conduct of a particularly reprehensible character: children are highly vulnerable members of society. Child abuse is also a form of criminal conduct peculiarly hard to combat, because its existence is difficult to discover. Babies and young children are unable to complain, older children too frightened. If the source of the abuse is a parent, the child is at risk from his primary and natural protector within the privacy of his home. This both increases the risk of abuse and means that investigation necessitates intrusion into highly sensitive areas of family life, with the added complication that the parent who is responsible for the abuse will give a false account of the child's history.

73. The other, countervailing interest is the deep interest of the parent in his or her family life. Society sets much store by family life. Family life is to be guarded jealously. This is reflected in article 8 of the European Convention on Human Rights. Interference with family life requires cogent justification, for the sake of children and parents alike. So public authorities should, so far as possible, cooperate with the parents when making decisions about their children. Public authorities should disclose matters relied upon by them as justifying interference with family life. Parents should be involved in the decision-making process to whatever extent is appropriate to protect their interests adequately.

74. The question raised by these appeals is how these countervailing interests are best balanced when a parent is wrongly suspected of having abused his child. Public confidence in the child protection system can only be maintained if a proper balance is struck, avoiding unnecessary intrusion in families while protecting children at risk of significant harm: see the Preface to 'Working Together', (1991). Clearly, health professionals must act in good faith. They must not act recklessly, that is, without caring whether an allegation of abuse is well-founded or not. Acting recklessly is not acting in good faith. But are health professionals liable to the suspected parents if they fall short of the standards of skill and care expected of any reasonable professional in the circumstances? Are they exposed to claims by the parents for professional negligence? Put differently and more widely, what is the

appropriate level of protection for a person erroneously suspected of child abuse? Should he be protected against professional negligence by those charged with protecting the child? Or only against lack of good faith?

75. In considering these questions the starting point is to note that in each of the three cases before the House the doctors acted properly in considering whether the claimant parents had deliberately inflicted injury on the child in question. The doctors were entitled, indeed bound, to consider this possibility. Further, having become suspicious, the doctors rightly communicated their suspicions to the statutory services responsible for child protection. This is the essential next step in child protection: see, for instance, ‘Working Together’, para 4.32.

76. In each case the suspected parent was eventually cleared of suspicion. In one case this was after ten days, in the other cases after much longer periods. The second point to note therefore is that, essentially, the parents’ complaints relate to the periods for which they remained under suspicion. In each case the parent’s complaint concerns the conduct of the clinical investigation during these periods: the investigation, it is said, was unnecessarily protracted. The doctors failed to carry out the necessary tests with appropriate expedition. Had due care and skill been exercised from the outset, the doctors’ suspicions would have been allayed at once or much more speedily than occurred and, in consequence, the parents would have been spared the trauma to which they were subjected. Thus the essence of the claims is that health professionals responsible for protecting a suspected child victim owe a person suspected of having committed a crime against the child a duty to investigate their suspicions, a duty sounding in damages if they act in good faith but carelessly.

77. Stated in this broad form, this is a surprising proposition. In this area of the law, concerned with the reporting and investigation of suspected crime, the balancing point between the public interest and the interest of a suspected individual has long been the presence or absence of good faith. Good faith is required but not more. A report, made to the appropriate authorities, that a person has or may have committed a crime attracts qualified privilege. A false statement (‘malicious falsehood’) attracts a remedy if made maliciously. Misfeasance in public office calls for an element of bad faith or recklessness. Malice is an essential ingredient of causes of action for the misuse of criminal or civil proceedings. In *Calveley v Chief Constable of the Merseyside Police* [1989] 1 AC 1228, 1238, Lord Bridge of Harwich observed that

‘where no action for malicious prosecution would lie, it would be strange indeed if an acquitted defendant could recover damages for negligent investigation’. This must be equally true of a person who has been suspected but not prosecuted.

78. This background accords ill with the submission that those responsible for the protection of a child against criminal conduct owe suspected perpetrators the duty suggested. The existence of such a duty would fundamentally alter the balance in this area of the law. It would mean that if a parent suspected that a babysitter or a teacher at a nursery or school might have been responsible for abusing her child, and the parent took the child to a general practitioner or consultant, the doctor would owe a duty of care to the suspect. The law of negligence has of course developed much in recent years, reflecting the higher standards increasingly expected in many areas of life. But there seems no warrant for such a fundamental shift in the long established balance in this area of the law.

Interference with family life

79. Understandably, Mr Langstaff QC did not contend for such a broad proposition. He did not submit that the health professionals owe a duty to whomsoever may be suspected of abuse. His submission was more restricted. He submitted that the health professionals’ duty to exercise due professional skill and care is owed only to the child’s primary carers, usually the parents, as well as the child himself. Mr. Langstaff submitted there was no good policy reason to deny the existence of such a restricted duty, which would not oblige a health professional to do more than he has to do anyway. The interests of the child and the parent would not be in conflict unless the parent was the abuser, which was not so in the present cases.

80. My initial difficulty with this submission is that the distinction between primary carers, to whom this duty would be owed, and other suspects, to whom it would not, is not altogether convincing. It is difficult to see why, if a health professional owes no duty to a childminder or school teacher suspected of abuse, he should nevertheless owe such a duty to a parent suspected of abuse. An erroneous suspicion that a childminder or school teacher has been abusing a child in his or her care can be very damaging to him or her. In the present case the complaints are that the parents suffered psychiatric

injury. This could occur equally in the case of the childminder or school teacher.

81. There is, however, one major difference between parents and childminders or school teachers. In the case of a parent suspicion may disrupt the parent's family life. That will not be so with the childminder or school teacher. So the crucial question on these appeals is whether this potential disruption of family life tilts the balance in favour of imposing liability in negligence where abuse by a parent is erroneously suspected.

82. There is little authority directly on this point. This is not surprising because the law has been developing remarkably swiftly in the field of child protection. Until recently it would have been unthinkable that health professionals owed a duty to parents; they did not owe a duty even to the child. But the law has moved on since the decision of your Lordships' House in *X (Minors) v Bedfordshire County Council* [1995] 2 AC 633. There the House held it was not just and equitable to impose a common law duty on local authorities in respect of their performance of their statutory duties to protect children. Later cases, mentioned by my noble and learned friend Lord Bingham of Cornhill, have shown that this proposition is stated too broadly. Local authorities may owe common law duties to children in the exercise of their child protection duties.

83. This development in the law gives no guidance on how 'wrongly suspected parent' cases should be decided. There have been a number of cases, in this country and in Strasbourg, involving claims by parents against local authorities in respect of the latter's discharge of their responsibilities regarding children. In only two cases, it seems, was the claimant a parent *wrongly* suspected of having abused his or her child. In *L (A Child) v Reading Borough Council* [2001] 1 WLR 1575 the Court of Appeal's decision concerned a striking out application. A police authority sought to strike out a claim in negligence brought by a father wrongly suspected of having sexually abused his daughter. Otton LJ held the police assumed no responsibility towards the father by interviewing him as a suspect. But it was arguable there was a legal assumption of responsibility when, there being no evidence to support criminal proceedings, the police officer nevertheless came to the conclusion that the mother's complaint was sufficient to show that the daughter was at risk of further abuse from her father. So the striking out application failed. The Court of Appeal left open the question whether there was a 'legal assumption of responsibility' on the alleged facts.

84. More recently a case concerning a wrongly suspected parent came before the European Court of Human Rights in *Venema v Netherlands* (2002) 39 EHRR 102. A young child aged 11 months was separated from her mother because of fears the mother was suffering from Munchausen syndrome by proxy. The child was returned five months later, following medical reports which found the child's arrested breathing had a physical explanation and that there was no sign the mother was suffering from any psychiatric disorder. The court noted that its approach in cases where a child has been taken into care is that it must be satisfied the circumstances justified taking such a step:

‘In this respect, [the court] must have particular regard to whether, *in the light of the case as a whole*, the reasons adduced to justify the measure were relevant and sufficient such as to allow the conclusion that it was “necessary in a democratic society”’(para 90, emphasis added).

In that case the court held there had been a breach of article 8 because the parents had not been sufficiently involved in the decision-making process. They had not been able to put forward their point of view before the court order was made.

85. In my view the Court of Appeal reached the right conclusion on the issue arising in the present cases. Ultimately the factor which persuades me that, at common law, interference with family life does not justify according a suspected parent a higher level of protection than other suspected perpetrators is the factor conveniently labelled ‘conflict of interest’. A doctor is obliged to act in the best interests of his patient. In these cases the child is his patient. The doctor is charged with the protection of the child, not with the protection of the parent. The best interests of a child and his parent normally march hand-in-hand. But when considering whether something does not feel ‘quite right’, a doctor must be able to act single-mindedly in the interests of the child. He ought not to have at the back of his mind an awareness that if his doubts about intentional injury or sexual abuse prove unfounded he may be exposed to claims by a distressed parent.

86. This is not to suggest doctors or other health professionals would be consciously swayed by this consideration. These professionals are surely made of sterner stuff. Doctors often owe duties to more than one person; for instance, a doctor may owe duties to his employer as well as his patient. But the seriousness of child abuse as a social problem

demands that health professionals, acting in good faith in what they believe are the best interests of the child, should not be subject to potentially conflicting duties when deciding whether a child may have been abused, or when deciding whether their doubts should be communicated to others, or when deciding what further investigatory or protective steps should be taken. The duty they owe to the child in making these decisions should not be clouded by imposing a conflicting duty in favour of parents or others suspected of having abused the child.

87. This is not to say that the parents' interests should be disregarded or that the parents should be kept in the dark. The decisions being made by the health professionals closely affect the parents as well as the child. Health professionals are of course fully aware of this. They are also mindful of the importance of involving the parents in the decision-making process as fully as is compatible with the child's best interests. But it is quite a step from this to saying that the health professionals personally owe a suspected parent a duty sounding in damages.

88. The claimants sought to meet this 'conflict of interest' point by noting that the suggested duty owed to parents has the same content as the duty owed to the child: to exercise due skill and care in investigating the possibility of abuse. This response is not adequate. The time when the presence or absence of a conflict of interest matters is when the doctor is carrying out his investigation. At that time the doctor does not know whether there has been abuse by the parent. But he knows that when he is considering this possibility the interests of parent and child are diametrically opposed. The interests of the child are that the doctor should report any suspicions he may have and that he should carry out further investigation in consultation with other child care professionals. The interests of the parent do not favour either of these steps. This difference of interest in the outcome is an unsatisfactory basis for imposing a duty of care on a doctor in favour of a parent.

89. This was the conclusion reached by the High Court of Australia in *Sullivan v Moody* (2001) 207 CLR 562. In Australia, as in this country, the professional and statutory responsibilities of doctors and other health professionals involve investigating and reporting allegations that a child has suffered serious harm or is at risk of doing so. The High Court held unanimously that it would be inconsistent with the proper and effective discharge of these responsibilities that those charged with these responsibilities should be subjected to a legal duty, sounding in damages, to take care to protect persons suspected of being the source of

that harm. Gleeson CJ, Gaudron, McHugh, Hayne and Callinan JJ said, at para 62:

‘The duty for which the [appellant fathers] contend cannot be reconciled satisfactorily, either with the nature of the functions being exercised by the [medical practitioners and others investigating allegations of child sex abuse], or with their statutory obligation to treat the interests of the children as paramount. As to the former, the functions of examination and reporting, require, for their effective discharge, an investigation into the facts without apprehension as to possible adverse consequences for people in the position of the appellants or legal liability to such persons. As to the latter, the interests of the children, and those suspected of causing their harm, are diverse, and irreconcilable. That they are irreconcilable is evident when regard is had to the case in which examination of a child alleged to be a victim of abuse does not allow the examiner to form a definite opinion about whether the child has been abused, only a suspicion that it *may* have happened. The interests of the child, in such a case, would favour reporting that the suspicion of abuse has not been dispelled; the interests of a person suspected of the abuse would be to the opposite effect.’

90. For these reasons I am not persuaded that the common law should recognise the duty propounded by Mr Langstaff. In principle the appropriate level of protection for a parent suspected of abusing his child is that clinical and other investigations must be conducted in good faith. This affords suspected parents a similar level of protection to that afforded generally to persons suspected of committing crimes.

91. This should be the general rule, where the relationship between doctor and parent is confined to the fact that the parent is father or mother of the doctor’s patient. There may, exceptionally, be circumstances where this is not so. Different considerations may apply then. But there is nothing of this sort in any of these three cases. The fact that a parent took the unexceptional step of initiating recourse to medical advice is not a special circumstance for this purpose. Nor is the fact that the parent took the child to a general practitioner or to a hospital to see a consultant.

Breach, and not duty, as the control mechanism

92. A wider approach has also been canvassed. The suggestion has been made that, in effect, the common law should jettison the concept of duty of care as a universal prerequisite to liability in negligence. Instead the standard of care should be 'modulated' to accommodate the complexities arising in fields such as social workers dealing with children at risk of abuse: Fairgrieve, Andenas and Bell, 'Tort Liability of Public Authorities in Comparative Perspective', page 485. The contours of liability should be traced in other ways.

93. For some years it has been all too evident that identifying the parameters of an expanding law of negligence is proving difficult, especially in fields involving the discharge of statutory functions by public authorities. So this radical suggestion is not without attraction. This approach would be analogous to that adopted when considering breaches of human rights under the European Convention. Sometimes in human rights cases the identity of the defendant, whether the State in claims under the Convention or a public authority in claims under the Human Rights Act, makes it appropriate for an international or domestic court to look backwards over everything which happened. In deciding whether overall the end result was acceptable the court makes a value judgment based on more flexible notions than the common law standard of reasonableness and does so freed from the legal rigidity of a duty of care.

94. This approach, as I say, is not without attraction. It is peculiarly appropriate in the field of human rights. But I have reservations about attempts to transplant this approach wholesale into the domestic law of negligence in cases where, as here, no claim is made for breach of a Convention right. Apart from anything else, such an attempt would be likely to lead to a lengthy and unnecessary period of uncertainty in an important area of the law. It would lead to uncertainty because there are types of cases where a person's acts or omissions do not render him liable in negligence for another's loss even though this loss may be foreseeable. My noble and learned friend Lord Rodger of Earlsferry has given some examples. Abandonment of the concept of a duty of care in English law, unless replaced by a control mechanism which recognises this limitation, is unlikely to clarify the law. That control mechanism has yet to be identified. And introducing this protracted period of uncertainty is unnecessary, because claims may now be brought directly against public authorities in respect of breaches of Convention rights.

95. For these reasons, and the reasons given by my noble and learned friends Lord Rodger of Earlsferry and Lord Brown of Eaton-under-Heywood, I would dismiss these appeals.

LORD STEYN

My Lords,

96. I have had the advantage of reading the opinions of my noble and learned friends Lord Nicholls of Birkenhead, Lord Rodger of Earlsferry and Lord Brown of Eaton-Under-Heywood. I agree with their opinions. I would dismiss the appeals.

LORD RODGER OF EARLSFERRY

My Lords,

97. The appellants, it must be assumed, developed a psychiatric illness and, in some cases, suffered financial loss as a result of a doctor or social worker, for whom the respondents are responsible, negligently concluding that their child had suffered abuse at their hands. While one could only sympathise with anyone in that plight, the question for your Lordships is whether the appellants have an arguable case for obtaining damages against the respondents for their illness and loss. (Since no separate issue arises in connexion with the social workers, for the sake of brevity, I shall simply refer to the position of the doctors.)

98. Plainly, if the issue depended simply on whether the doctors' careless acts caused their illness and loss, the appellants would have pleaded a powerful case for damages. Equally plainly, however, while foreseeability and causation are necessary elements in any successful claim for damages based on negligence, they are not sufficient: in the contemplation of the law, the respondents are liable to the appellants only if the doctor owed them a duty of care. The concept of the duty of care was famously described, some seventy years ago, as "an unnecessary fifth wheel on the coach", but it remains an integral part of the way the courts determine whether there is liability for negligence.

99. On this occasion the issue comes before the House in an appeal from a decision by the Court of Appeal to strike out the appellants' claims. Often the question of liability may depend on nuances of fact which may well only emerge at trial. If so, the case must, of course, proceed to trial. But a court can strike out a claim where the statement of claim discloses no reasonable grounds for bringing the claim. In the present cases it is fair to assume that the evidence at any trial might throw up new facts about the conduct of the doctors and social workers. But on behalf of the appellants Mr Langstaff, QC, did not suggest that any unresolved issues of fact might be decisive in determining the existence of a duty of care. On the contrary, he contended that the pleadings and the agreed statement of facts already disclosed a situation where, in each case, the defendants owed a duty of care to the claimants. That being so, if your Lordships are satisfied that the pleadings and agreed facts do not in fact disclose a valid cause of action, it is to the advantage of all concerned that the claims should not proceed to what would be a costly but inevitably fruitless trial. The relevant events all occurred long before the Human Rights Act 1998 came into force. But, if, for the purposes of the European Convention or otherwise, there were a need to investigate what happened in these cases, other appropriate means could be found.

100. In the field of negligence the common law "develops incrementally on the basis of a consideration of analogous cases where a duty has been recognised or desired": *Marc Rich & Co AG v Bishop Rock Marine Co Ltd* [1996] AC 211, 236B - C per Lord Steyn. The test to be applied is whether the situation is one "in which the court considers it fair, just and reasonable that the law should impose a duty of a given scope upon the one party for the benefit of the other": *Caparo Industries plc v Dickman* [1990] 2 AC 605, 618A per Lord Bridge of Harwich. In applying that test, the court has regard to analogous cases where a duty of care has, or has not, been held to exist. On the other hand, when applying the test, I do not actually find it helpful to bear in mind – what is in any event obvious – that the public policy consideration which has first claim on the loyalty of the law is that wrongs should be remedied. Harm which constitutes a "wrong" in the contemplation of the law must, of course, be remedied. But the world is full of harm for which the law furnishes no remedy. For instance, a trader owes no duty of care to avoid injuring his rivals by destroying their long-established businesses. If he does so and, as a result, one of his competitors descends into a clinical depression and his family are reduced to penury, in the eyes of the law they suffer no wrong and the law will provide no redress – because competition is regarded as operating to the overall good of the economy and society. A young man whose fiancée deserts him for his best friend may become clinically

depressed as a result, but in the circumstances the fiancée owes him no duty of care to avoid causing this suffering. So he too will have no right to damages for his illness. The same goes for a middle-aged woman whose husband runs off with a younger woman. Experience suggests that such intimate matters are best left to the individuals themselves. However badly one of them may have treated the other, the law does not get involved in awarding damages.

101. Other relationships are also important. We may have children, parents, grandparents, brothers, sisters, uncles and aunts - not to mention friends, colleagues, employees and employers – who play an essential part in our lives and contribute to our happiness and prosperity. We share in their successes, but are also affected by anything bad which happens to them. So it is - and always has been - readily foreseeable that if a defendant injures or kills someone, his act is likely to affect not only the victim but many others besides. To varying degrees, these others can plausibly claim to have suffered real harm as a result of the defendant's act. For the most part, however, the policy of the law is to concentrate on compensating the victim for the effects of his injuries while doing little or nothing for the others. In technical language, the defendants owe a duty of care to the victim but not to the third parties, who therefore suffer no legal wrong.

102. So, when someone negligently kills another, at common law his relatives have no right to recover damages for the distress and loss which this causes them. Of course, sections 1(1) and 1A of the Fatal Accidents Act 1976 modify the common law by providing that the wrongdoer is liable to certain dependants for the loss they suffer due to the death of the victim, and to certain relatives for their bereavement. But the defendant is liable only if he would have been liable to the victim if he had lived. The statute thus remains true to the common law position that the tortfeasor owed a duty of care to the victim but not to the dependants. So, for instance, a surgeon operating on a child will readily foresee that, if he is careless and the child dies, her parents will suffer extreme distress which may well make them ill. Nevertheless, her parents will have no common law right to damages for that distress or illness. They may have a claim for bereavement damages under section 1A of the 1976 Act - but only because the surgeon owed a duty of care to their daughter, as his patient.

103. The common law is to the same effect where the victim does not die, but is severely injured: it provides compensation to the victim but not to others, however severely they may be affected. Lord Morton of

Henryton explained the position in *Best v Samuel Fox & Co Ltd* [1952] AC 716, 734:

“it has never been the law of England that an invitor, who has negligently but unintentionally injured an invitee, is liable to compensate other persons who have suffered, in one way or another, as a result of the injury to the invitee. If the injured man was engaged in a business, and the injury is a serious one, the business may have to close down and the employees be dismissed; a daughter of the injured man may have to give up work which she enjoys and stay at home to nurse a father who has been transformed into an irritable invalid as a result of the injury. Such examples could easily be multiplied. Yet the invitor is under no liability to compensate such persons, for he owes them no duty and may not even know of their existence.”

When, for a moment, in *Dick v Burgh of Falkirk* 1976 SC (HL) 1, 23, it looked as though some members of your Lordships' House had been prepared to contemplate the idea of a defender owing a common law duty of care to the victim's relatives, their Lordships soon saw the need to recant: *Robertson v Turnbull* 1982 SC (HL) 1. Consistently with this overall approach, it is the victim who sues the tortfeasor for the value of any gratuitous care provided by a relative and then holds the damages in trust for the carer. This somewhat cumbersome approach is necessary because the carer herself is owed no duty and cannot sue.

104. Lord Oliver of Aylmerton analysed these aspects of the law of negligence in *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310, 410E - G:

“The failure of the law in general to compensate for injuries sustained by persons unconnected with the event precipitated by a defendant's negligence must necessarily import the lack of any legal duty owed by the defendant to such persons. That cannot, I think, be attributable to some arbitrary but unenunciated rule of 'policy' which draws a line as the outer boundary of the area of duty. Nor can it rationally be made to rest upon such injury being without the area of reasonable foreseeability. It must, as it seems to me, be attributable simply to the fact that such persons

are not, in contemplation of law, in a relationship of sufficient proximity to or directness with the tortfeasor as to give rise to a duty of care, though no doubt ‘policy’, if that is the right word, or perhaps more properly, the impracticability or unreasonableness of entertaining claims to the ultimate limits of the consequences of human activity, necessarily plays a part in the court’s perception of what is sufficiently proximate.”

In the present case it is apposite to recall that, a fortiori, the common law does not give damages “for the mental anguish and even illness which may flow from having lost a wife, parent or child or from being compelled to look after an invalid...”: [1992] 1 AC 310, 409G – H per Lord Oliver. So, for instance, if a doctor carelessly fails to diagnose a child’s illness and, as a result, her distraught parents, who have to nurse her over many months, suffer psychiatric harm, they recover nothing by way of damages – because, in the contemplation of the law of tort, the doctor and the patient’s parents are not in a relationship of sufficient proximity or directness as to give rise to a duty of care to them on the part of the doctor.

105. For the most part, then, the settled policy of the law is opposed to granting remedies to third parties for the effects of injuries to other people. The appellants are seeking to introduce an exception to that approach.

106. The defendants now accept that the doctors owed a duty of care to the children whom they examined and assessed. As the precedents show, it by no means follows that they owed any similar duty of care to the parents. Here the appellants formulate the alleged duty in this way: the doctors were under a duty not to cause harm to a parent foreseeably at risk of suffering harm by failing to exercise reasonable and proper care in making a diagnosis of child abuse. Despite the terms of the alleged duty, counsel for the appellants was at pains to argue that in substance it was the same as the duty which the doctors already owed to the child: if they performed their duty to the child, they would ipso facto perform their duty to the parents. As I shall suggest in a moment, assimilating the two duties in this way tends to conceal the real nature of the appellants’ complaint. But, even on counsel’s formulation, the similarity in the content of the two duties is no reason for holding that the supposed duty was owed to the parents. The content of a duty of care and the range of persons to whom it is owed are quite separate matters, the latter raising issues of proximity. For instance, when riding

his motorbike, John Young owed certain other road users a duty of care to avoid injuring them, but he did not owe that duty to Mrs Bourhill alighting on the other side of the tram – even though, in substance, any duty of care to her in the way he drove his motorbike would have been the same as the one he already owed to the other road users: *Bourhill v Young* [1943] AC 92. In *Alcock v Chief Constable of South Yorkshire Police* the House dismissed the plaintiffs' claims, even although, again, as a practical matter the content of the duty which they said was owed to them was no different from the content of the duty which the chief constable admittedly owed to the people killed or injured in the crush. The plaintiffs were simply not persons to whom he owed that duty.

107. Nervous shock forms a particular chapter of the law. A defendant may owe a duty of care not only to the person whom he injures but also to that person's parents or spouse who suffer nervous shock through seeing or hearing the event or its immediate aftermath: *McLoughlin v O'Brian* [1983] 1 AC 410. Medical mishaps can give rise to such a duty. So, for example, where doctors negligently failed to carry out a Caesarean section and the baby died two days later, the health authority were liable to the parents who developed a psychiatric illness as a result of the shocking and direct impact of the delivery and of the baby's struggle for life: *Tredget and Tredget v Bexley Health Authority* [1994] 5 Med LR 178. Similarly, in *North Glamorgan NHS Trust v Walters* [2003] Lloyd's Rep Med 49, a mother recovered damages for the pathological grief reaction which she suffered as a result of witnessing, experiencing and participating in the events leading up to her baby's death due to the defendants' negligent failure to diagnose his condition. In the present cases, however, the appellants do not allege that they suffered nervous shock in that way and so their claims do not come within the reach of that distinct line of authority.

108. That being so, on the assumption that the appellants are claiming the same duty of care as was owed to their children, it seems to me that there would have to be some factor, over and above the foreseeable harm which the parents suffered, before the law would hold that the doctors and parents were in sufficient proximity to give rise to a duty of care. Mr Langstaff suggested that the necessary degree of proximity could be found in the fact that the parents themselves had taken the children to see the doctor. That is indeed what happened in these cases. But in itself this can hardly be a criterion for attaching liability to the defendants. For example, there is nothing in the nervous shock cases to suggest that taking the child to the hospital would, in itself, create the necessary proximity for a successful claim by her parents. Something more, by way of actually experiencing the critical event, is required.

More generally, it would in my view be unacceptable for a doctor to be liable in damages to a father who took his daughter to the surgery, but not to a father whose daughter happened to be taken by someone else who was looking after her for the day when her symptoms developed. If that supposed distinction is rejected, I am unable to see why it would be fair, just and reasonable for the doctors to owe the parents a duty of care of this kind when, for instance, a defendant who negligently injures a child travelling in his car owes no duty of care to the parents who may foreseeably develop a psychiatric illness as a result of the strain of caring for her. I would therefore reject the appellants' submission that the defendants owed substantially the same duty of care to the parents as to the children.

109. As I have said, counsel for the appellants was anxious to present their case as one where the duty to the child and the duty to the child's parents in effect coincided. In this way he sought to outflank the objection that there is a potential conflict of interest between the child and the parents in a case of alleged child abuse. But this bland version of the supposed duty of care underplays, if it does not eliminate, what I would regard as the most powerful element in the case for the appellants: that by concluding that the children had been the subject of abuse or deliberate harm, the doctors simultaneously indicated that the appellants *themselves* had been responsible for the abuse or harm. It was, one might suppose, this devastating suggestion which caused the appellants the distress that resulted in their illness. As the High Court of Australia put it in *Sullivan v Moody* (2001) 207 CLR 562, 581, para 54, "the core of the complaint by each appellant is that he [or she] was injured as a result of what he [or she], and others, were told." It is precisely this very personal defamatory wound which distinguishes their claims from, say, the claims of parents who become ill due to the strain of caring for a child who has become disabled as a result of a surgeon's negligence. On this more focussed approach the health authority would be under a specific duty to take reasonable care to avoid causing a parent psychiatric injury by concluding that he had abused or harmed his child. Viewed in isolation, much might indeed be said for a duty of this kind which would mean that, when deciding how to proceed where they suspected that a child had been abused, the doctors would have to take account of the very real risk of harming the parents in this way.

110. In considering whether it would be fair, just and reasonable to impose such a duty, a court has to have regard, however, to all the circumstances and, in particular, to the doctors' admitted duty to the children. The duty to the children is simply to exercise reasonable care and skill in diagnosing and treating any condition from which they may

be suffering. In carrying out that duty the doctors have regard only to the interests of the children. Suppose, however, that they were also under a duty to the parents not to cause them psychiatric harm by concluding that they might have abused their child. Then, in deciding how to proceed, the doctors would always have to take account of the risk that they might harm the parents in this way. There would be not one but two sets of interests to be considered. Acting on, or persisting in, a suspicion of abuse might well be reasonable when only the child's interests were engaged, but unreasonable if the interests of the parents had also to be taken into account. Of its very nature, therefore, this kind of duty of care to the parents would cut across the duty of care to the children.

111. The need to put the interests of the child first in any case of suspected abuse is a theme which runs through the guidance in *Working Together* (1991) which was issued under section 7 of the Local Authority Social Services Act 1970. Doctors and social workers must be alert to possible signs of abuse. If they suspect that a child is suffering, or is at risk of suffering, significant harm, they should refer their concern to the appropriate agency (para 5.11.1). They are specifically warned, moreover, that the interests of parents and children may conflict and that in such cases the child's interests should be the priority (para 6.12). The real dangers of such a potential conflict are more than amply vouched by the statements of Professor Sir Alan Craft and Mary Marsh which my noble and learned friend, Lord Brown of Eaton-under-Heywood, has quoted. I see no basis whatever for brushing them aside. On the contrary, the appropriate response of the law is to recognise and minimise these dangers. It does so by holding that in these cases the doctors do not owe a duty of care to the parents.

112. That was indeed the response of Sir Thomas Bingham MR in *X (Minors) v Bedfordshire County Council* [1995] 2 AC 633, 665G – H, where he held that the psychiatrist owed a duty of care to the child whom she was examining, but no duty of care to the child's mother:

“The psychiatrist would in my view have recognised the mother as someone foreseeably likely to be injured if, as a result of her advice, the child were to be taken away from the mother. But the mother was not in any meaningful sense the psychiatrist's patient. The psychiatrist's duty was to act in the interests of the child, and that might very well mean acting in a way that would be adverse to the personal interests of the mother; she was concerned with

those interests only to the extent that they could have an impact on the interests of the child. In this situation of potential conflict, I do not think the psychiatrist can arguably be said to have owed a duty of care to the mother, whose claim it was accordingly right to strike out.”

This House, of course, went further and held that the psychiatrist owed no duty of care to the child. But there is nothing in the speech of Lord Browne-Wilkinson which would cast any doubt on Sir Thomas Bingham’s analysis, on the assumption that such a duty was in fact owed to the child.

113. The High Court of Australia came to a similar conclusion in *Sullivan v Moody* (2001) 207 CLR 562. Parents had been suspected of abusing their children. They asserted that the doctors and social workers, operating under a statutory scheme for protecting children, owed them a duty of care. Rejecting that argument, their Honours noted, p 582, para 60, that while someone might be under duties to more than one person, nevertheless “if a suggested duty of care would give rise to inconsistent obligations, that would ordinarily be a reason for denying that the duty exists.” They went on to note that the statutory scheme required the medical practitioners to treat the interests of the children as paramount. In these circumstances, they said, p 582, para 62:

“It would be inconsistent with the proper and effective discharge of those responsibilities that they should be subjected to a legal duty, breach of which would sound in damages, to take care to protect persons who were suspected of being the sources of that harm. The duty for which the appellants contend cannot be reconciled satisfactorily, either with the nature of the functions being exercised by the respondents, or with their statutory obligation to treat the interests of the children as paramount. As to the former, the functions of examination, and reporting, require, for their effective discharge, an investigation into the facts without apprehension as to possible adverse consequences for people in the position of the appellants or legal liability to such persons. As to the latter, the interests of the children, and those suspected of causing their harm, are diverse, and irreconcilable. That they are irreconcilable is evident

when regard is had to the case in which examination of a child alleged to be a victim of abuse does not allow the examiner to form a definite opinion about whether the child had been abused, only a suspicion that it *may* have happened. The interests of the child, in such a case, would favour reporting that the suspicion of abuse has not been dispelled; the interests of a person suspected of the abuse would be to the opposite effect.”

114. Similarly, in *B and others v Attorney General of New Zealand* [2003] 4 All ER 833, para 30, my noble and learned friend, Lord Nicholls of Birkenhead, giving the judgment of the Privy Council, pointed out that in an investigation of alleged child abuse, the father, as the alleged perpetrator of the abuse, stood in a very different position from the child, as the alleged victim of that abuse. To impose a common law duty of care in favour of the alleged victims and, at one and the same time, in favour of the alleged perpetrator would not be satisfactory. The Board accordingly eliminated the risk of any potential conflict of interests by holding that those investigating alleged abuse owed no common law duty of care to the father.

115. It is unnecessary to multiply these citations. They constitute powerful support for the Court of Appeal’s conclusion, [2004] QB 558, 591, para 86, that there are cogent reasons of public policy for holding that no common law duty of care should be owed to the parents. I respectfully agree with their view and would accordingly hold that it is not fair just and reasonable to impose such a duty.

116. For the sake of completeness, I add two points.

117. First, if, contrary to my view, a duty of care were to be imposed in favour of the parents in these cases, I could see no proper basis for then failing to extend it to other members of the family, to friends of the family, to teachers and to child-minders – in short, to anyone who might come under suspicion of having abused the child. The potentially wide range of this supposed additional duty could only add to the risk that it would compromise the key duty of care to the children.

118. Secondly, since the relevant events occurred before the Human Rights Act 1998 came into force, the appellants could not seek damages for any possible breach of their rights under article 8(1). Especially in

view of the decisions in *Wainwright v Home Office* [2004] 2 AC 406, 423, para 34, and *R v Secretary of State for the Home Department, Ex p Greenfield* [2005] UKHL 14; [2005] 1 WLR 673 I should wish to reserve my opinion as to whether, in such a case, it would be appropriate to modify the common law of negligence, rather than to found any action on the provisions, including section 8, of the Human Rights Act. Cf *Fairlie v Perth and Kinross Healthcare NHS Trust* 2004 SLT 1200, 1209L, para 36 per Lord Kingarth.

119. For these reasons, as well as those given by my noble and learned friends, Lord Nicholls of Birkenhead and Lord Brown of Eaton-Under-Heywood, with whose speeches I am in entire agreement, I too would dismiss the appeal.

LORD BROWN OF EATON-UNDER-HEYWOOD

My Lords,

120. The appellants in these cases are parents who were wrongly suspected of child abuse through the misdiagnosis of their children by doctors. Each in consequence suffered psychiatric disorder. In each case the true explanation for the child's condition was not discovered until regrettably late.

121. In the first case a five-year old child with multiple severe allergies was wrongly thought instead to have been mistreated by his mother, misdiagnosed as suffering from Munchausen's Syndrome by Proxy. In the result the child was placed on the "at risk register" for some months. In the second case a nine-year old child presenting with discoloured skin patches, caused in fact by Schamberg's Disease, was instead provisionally diagnosed as having been sexually abused so that for some weeks her father was prevented from seeing her. In the third case a two month old child suffered a spiral fracture of the femur whilst being lifted from a settee, an injury wrongly regarded by the doctor as non-accidental although in fact resulting from osteogenesis imperfecta (brittle bone disease), a condition only diagnosed some eight months later when the child suffered bilateral femoral fractures whilst in the care of an aunt under an interim care order.

122. In each case it is to be assumed for the purposes of these appeals that the respective doctors failed in their investigation and diagnosis of the child's condition to exercise reasonable and proper professional care, failures which would render them liable in damages for injuries suffered by anyone to whom they owed a duty of care. If, indeed, the allegations made in these cases are well-founded (as for present purposes is to be assumed) the doctors appear to have displayed an egregious over-confidence in their own opinions and a marked reluctance to test them.

123. It is easy in these circumstances to understand the appellants' evident sense of grievance at their treatment and impossible not to sympathise with them in their plight. It does not follow, however, that the law should in these circumstances create a right of redress in the parents by imposing upon the doctors a duty of care never previously recognised to exist, a duty not to the child as the patient but rather to the parents in their own right.

124. It is said in favour of creating such a duty that the doctor will not thereby be required to act any differently from the way he must already act. In his care of the child he is bound to consider and investigate any reasonable suspicion that the child may have been abused. That is a duty which it is now accepted the doctor owes to the child and in discharging it he is required to exercise all reasonable and proper professional care. If he breaches that duty—whether by negligently failing to recognise the risk of child abuse so that the child is left unprotected against it (which for convenience may be called the negligent non-diagnosis of risk) or by negligently finding a child to be at risk so that he or she is needlessly removed from home (the negligent diagnosis of risk)—the child will have a cause of action for whatever loss he or she may have suffered. Postulate then, as these appeals do, that the doctor's negligence has been of the second kind, the negligent diagnosis of risk, and that, whether or not the child has suffered loss, the parent foreseeably has, in the form of psychiatric injury. Why should not the doctor be additionally liable for that? There are, submit the appellants, no sufficient policy considerations militating against such a conclusion; on the contrary “the public policy consideration which has first claim on the loyalty of the law is that wrongs should be remedied”—Lord Browne-Wilkinson in *X (Minors) v Bedfordshire County Council* [1995] 2 AC 633, 749, approving Sir Thomas Bingham MR's words in the Court of Appeal ([1995] 2 AC 633, 663).

125. The first difficulty with this argument is its apparent irreconcilability with a consistent stream of authority from *X v*

Bedfordshire onwards holding that no duty of care is owed in these circumstances to parents (whatever may be the child's position). I confine myself to citations from three cases only (each deciding, or at least assuming, that, contrary to the conclusion reached in *X v Bedfordshire* itself, a duty of care is indeed owed to the child). First, the opinion of the Privy Council given by my noble and learned friend Lord Nicholls in *B v Attorney General of New Zealand* [2003] 4 All ER 833, 841:

“[T]heir Lordships consider no common law duty of care was owed to the father. He stands in a very different position. He was the alleged perpetrator of the abuse. In an inquiry into an abuse allegation the interests of the alleged perpetrator and of the children as the alleged victims are poles apart. Those conducting the inquiry must act in good faith throughout. But to impose a common law duty of care on the department and the individual professionals in favour of the alleged victims or potential victims and, at one and the same time, in favour of the alleged perpetrator would not be satisfactory. Moreover, a duty of care in favour of the alleged perpetrator would lack the juridical basis on which the exercise of the common law duty of care was largely founded in *Prince's* case [of the New Zealand Court of Appeal]. The decision in *Prince's* case rests heavily on the feature that the duty imposed [by the New Zealand legislation] is for the benefit of the particular child. Self-evidently this statutory duty was not imposed for the benefit of alleged perpetrators of abuse. To utilise the existence of this statutory duty as the foundation of a common law duty in favour of perpetrators would be to travel far outside the rationale in *Prince's* case.”

126. Secondly, the judgment of the Court of Appeal in the present case [2004] QB 558, 591, at para 86:

“The Strasbourg cases demonstrate that failure to remove a child from the parents can as readily give rise to a valid claim by the child as a decision to remove the child. The same is not true of the parents' position. It will always be in the parents' interests that the child should not be removed. Thus the child's interests are in potential conflict with the interests of the parents. In view of this,

we consider that there are cogent reasons of public policy for concluding that, where child care decisions are being taken, no common law duty of care should be owed to the parents.”

127. Thirdly, Hale LJ’s judgment in *A v Essex County Council* [2004] 1 WLR 1881, 1900 :

“A balance has to be struck between the interests of all three parties to the adoption triangle, the prospective adopters, the birth parents and the child. But the agency’s first duty is towards the child. If, therefore, there is to be any duty of care in tort, it should be towards the child. The child is the most vulnerable person in the whole transaction; the one who is most likely to suffer lasting damage if things go wrong; who rarely has much choice in the matter; and is least able to protect his own interests. His interests may well conflict with those of any of the adult parties to the triangle.”

128. It is Mr Langstaff QC’s submission on behalf of the appellants that these judgments are all founded on a false premise; in truth, he submits, there is no conflict or even potential conflict between the interests of the child and those of the parent. The child’s interests are always paramount. If the child’s interests dictate that the parent be suspected of abuse and the child removed from home, so be it. There can be no countervailing interest in the parent capable of outweighing the child’s interests. Recognising, however, that, if the doctor were to form a wholly unreasonable suspicion of child abuse and in this way negligently cause the child’s removal from home he is thereby likely to injure the parent too, the doctor should be liable for that injury no less than for any injury to the child.

129. The argument, though at first blush plausible, is to my mind unsustainable. If the doctor is to be held liable in law for any injury to the parent occasioned by the taking of his child into care, that can only be because the doctor, in fulfilling his primary duty to safeguard the child against abuse, also owed the parent a separate duty to take account of his, the parent’s interest, in not being unreasonably suspected of child abuse. I find it impossible to see how such a duty could fail to impact upon the doctor’s approach to his task and create a conflict of interest. Of course, if he acts within the bounds of proper professional skill and

care he is liable to no one. But if he were to act negligently he would know that whereas a negligent non-diagnosis of child abuse would expose him to liability only to the child, a negligent diagnosis based on suspicions unreasonably held would render him liable also to the parent.

130. Were it possible to harbour doubts on the matter, the evidence now before your Lordships in the form of statements from Professor Sir Alan Craft of the Department of Child Health at Newcastle University and Mary Marsh of the NSPCC must surely resolve them. Child abuse, it appears, is appallingly prevalent in our society and all too often, alas, undetected. As Professor Craft explains:

“[T]he diagnosis depends upon the doctor rejecting the history that is given. The small child cannot describe the history, the older child is too frightened and the carer is commonly the perpetrator and gives a false history.

... [I]t is something for which paediatricians must always be on the lookout... At the end of the consultation the doctor may well be able to say no more than ‘This does not feel quite right’. ... [I]t often depends upon a piecing together of a mosaic of evidence from a number of different sources. The individual professional may feel that there is something ‘not quite right’ about a case without having the sort of evidence which would convince a court that it is in the child’s interest to be taken away from home. The doctor then has to make a judgment either to share the information with other professionals or to take the easy option and to send the child home, accepting the limitations imposed by his inability to test what the parents have said against other evidence. Only if the information is shared will it be seen beside other parts of the mosaic so that the picture will emerge. . . . If harm to children is to be reduced, the inevitable implication of this must be that a number of referrals will be made when the evidence of child abuse is at best tentative and where further investigation demonstrates that the concern was ill-founded. ... In those cases the child could suffer some damage as a result of the investigations necessary to allay the concern. However this damage should be temporary and marginal if the matter is properly handled, and comparatively easy to justify if a doctor is not acting irrationally. By contrast many parents will suffer embarrassment and real distress if the allegation is made, whether it is justified or not and however sensitively it is

put. If a duty of care is imposed in relation to the parent then the risk to the child may increase. The interests of the child and the parent do not coincide. In attempting to discharge a duty owed to the parent the paediatrician may decide not to refer a case to the local authority. If in that case the parent is harming the child then in attempting to discharge the duty to the parent the child will be put at risk of further harm. In order to discharge their obligations to the child, to protect it from further harm and to protect siblings, a doctor must be allowed to raise what sometimes may be no more than a suspicion with the relevant authorities without fear of litigation from the child's parents."

131. Mary Marsh states:

"[T]he work of the NSPCC and others concerned with the protection of children depends crucially on the courage and expertise of doctors. It is all too easy for the doctor to accept that the evidence presented in a busy Out Patient Clinic was caused as the parent says, and to ignore the subtle signs that should make it clear that returning this child to the home risks life as well as health. The line of least resistance could easily be more attractive for the doctor: quite apart from the parental pressures, the investigation of such suspicion will self-evidently increase the pressure on cots, waiting lists and the doctor's own time. ... We believe that doctors should have a duty to share their suspicions, to say when things do not feel right. They may have nothing specific to support that feeling, but the one small piece of information they have may when taken with others, reveal the whole picture. ... No-one should be sued for raising the possibility if they are acting bona fide in the interests of the child as they see it. ... It is particularly important that the professional, of whatever discipline, recognises that the paramount duty is to the child patient and not the parent. For most children, happily, there is a congruity of interest between the child and his/her parents. The parents are the gatekeepers to the child's future. But for children at risk of abuse, especially those at the most ominous risk, there may not be congruity of interest but rather conflict of interest. That is why the welfare needs and interests of the child must be paramount."

132. Those comparatively brief passages from the evidence highlight what in any event seems plain. Doctors have a vital part to play in combating the risk of child abuse. Nothing must be done to discourage them in that task. “The easy option” (Professor Craft), “the line of least resistance” (Mary Marsh), will always be for the doctor to accept the explanations given and to suppress his doubts. What is needed, however, is that doctors should act with “courage” (Mary Marsh), when they feel that something “is not quite right” (Professor Craft), although there is “nothing specific to support that feeling” (Mary Marsh), and when “the evidence of child abuse is at best tentative.” (Professor Craft). In these cases “the interests of the child and the parent do not coincide” (Professor Craft); “for children at risk of abuse, especially those at the most ominous risk, there may not be congruity of interest but rather conflict of interest.” (Mary Marsh)

133. There are other powerful considerations too militating against the imposition of a duty of care to parents arising out of the doctor’s discharge of his role in combating child abuse. These perhaps are best discerned by reference to the legal principles applying in certain related situations. Take a doctor whose negligent diagnosis or treatment of a child causes it to die with the result that the bereaved parent suffers psychiatric injury. Whilst clearly in such a case the parent can bring a claim on behalf of the child’s estate under the Law Reform (Miscellaneous Provisions) Act 1934, there can be no claim by the parent in respect of his own loss unless exceptionally he can bring himself within the narrow parameters recognised to give rise to secondary liability—see for example the decision of the Court of Appeal in *North Glamorgan NHS Trust v Walters* [2003] Lloyd’s Rep Med 49. The law has always placed strict limitations upon the right to recover for psychiatric injury and it is not easy to see why, if no such right exists in a father whose child is negligently allowed to die, it should be given to a father wrongly suspected of child abuse. In the first case the child is lost forever; in the second for a comparatively short time.

134. If it be said that in the second case the father’s reputation is blackened, the law’s response must be that a defamatory communication in the context of reporting suspicions of child abuse would inevitably attract the defence of qualified privilege so that liability would arise only on proof of malice, not mere negligence. The reason for such a rule is obvious: the law is concerned to encourage candour in such communications; doctors should not feel inhibited in reporting their concerns.

135. I acknowledge that this principle did not prevent the House from finding a duty of care owed by an employer to his employee with regard to the preparation of a reference—*Spring v Guardian Assurance plc* [1995] 2 AC 296. But the speeches of the majority clearly emphasise the importance to that decision of the employer-employee relationship. Ordinarily, when considering the imposition of a duty of care previously unrecognised by the law, the courts are astute not to create a conflict of interest. Lord Browne-Wilkinson’s speech in *White v Jones* [1995] 2 AC 207, 276 illustrates the point:

“[N]egligence in the preparation and execution of a will has certain unique features. First, there can be no conflict of interest between the solicitor and client (the testator) and the intended beneficiary. There is therefore no objection to imposing on a solicitor a duty towards a third party there being no possible conflict of interest.”

136. Another related situation to that presently under consideration is where a doctor prepares evidence with a view to appearing in a child abuse case as a witness. In this event, of course, an absolute immunity or privilege attaches to his evidence. Not for a moment do I suggest that that was the position in any of these cases; the Court of Appeal examined and rejected such a claim on behalf of the social workers in the *Dewsbury* case and no appeal arises as to that. The point to be made, however, is that the public interest in law enforcement and the administration of justice does sometimes require potential liabilities to be excluded notwithstanding that those “wronged” are left uncompensated. The limitations on the tort of malicious prosecution and the court’s refusal to recognise a duty of care in cases such as *Calveley v Chief Constable of the Merseyside Police* [1989] AC 1228 (the allegedly negligent conduct of disciplinary proceedings against police officers), *Elguzouli-Daf v Commissioner of Police of the Metropolis* [1995] QB 335 (the allegedly negligent prosecution of crime) and *Kumar v Commissioner of Police of the Metropolis* (unreported) 31 January 1995 (again the allegedly negligent institution and prosecution of an offence) are further examples in point.

137. There is always a temptation to say in all these cases that no one, whether a doctor concerned with possible child abuse, a witness or a prosecutor will ever in fact be held liable unless he has conducted himself manifestly unreasonably; it is unnecessary, therefore, to deny a duty of care, better rather to focus on the appropriate standard by which to judge whether it is breached. That, however, is to overlook two

fundamental considerations: first, the insidious effect that his awareness of the proposed duty would have upon the mind and conduct of the doctor (subtly tending to the suppression of doubts and instincts which in the child's interests ought rather to be encouraged), and second, a consideration inevitably bound up with the first, the need to protect him against the risk of costly and vexing litigation, by no means invariably soundly based. This would seem to me a very real risk in the case of disgruntled parents wrongly suspected of abuse; all too readily they might suppose proceedings necessary to vindicate their reputation.

138. I return to where I began, readily acknowledging the legitimate grievances of these particular appellants, against whom no suspicions whatever remain, sufferers from a presumed want of professional skill and care on the part of the doctors treating their children. It is they, I acknowledge, who are paying the price of the law's denial of a duty of care. But it is a price they pay in the interests of children generally. The well-being of innumerable children up and down the land depends crucially upon doctors and social workers concerned with their safety being subjected by the law to but a single duty: that of safeguarding the child's own welfare. It is that imperative which in my judgment must determine the outcome of these appeals. For these reasons, together with those given by my noble and learned friends Lord Nicholls of Birkenhead and Lord Rodger of Earlsferry, I would dismiss them.