Neutral Citation Number: [2018] EWHC 3132 (QB)

Case No: HQ16C04362

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/11/2018

Before :

MRS JUSTICE WHIPPLE DBE

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Between :

SUE (SUSAN) BOT (1) **KEITH WHITEHEAD (2)**	**Claimants**
- and -	
MR CHRISTIAN BARNICK (1) **DR JULIUS BOURKE (2)** **HCA INTERNATIONAL LIMITED (WRONGLY SUED AS THE PORTLAND HOSPITAL) (3)**	**Defendants**

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Claimant (1) not represented.
Adam Walker (instructed by **Healys LLP**) for **Claimant (2)**
Nicola Campbell-Clause (instructed by **Hill Dickinson LLP**) for **Defendants (1) and (2)**
Matthew Barnes (instructed by **DAC Beachcroft**) for **Defendant (3)**

Hearing dates: 1st November 2018

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Judgment Approved

Mrs Justice Whipple :

Introduction

1. These are two applications brought by the first and second defendants (D1 and D2), and the third defendant (D3), respectively, to strike out the second claimant's claim (he is C2). The strike out proceeds on two bases: that the claim discloses no reasonable cause of action (CPR 3.4(2)(a)); alternatively, that the claim has no real prospect of success (CPR 24.2).

2. By a claim form issued on 16 December 2016, the first Claimant (C1) claimed damages for personal injuries sustained and losses and expenses incurred as a result of the negligent treatment of D1 (a consultant obstetrician) and D2 (a consultant psychiatrist) at the Portland Hospital, for which D3 is responsible. C2 made a claim for damages and losses and expenses for negligent misstatement and breach of

contract by D1 and D2, and D3 and its servants or agents, between 25 April and 5 May 2011.

3. C1's claim against D1 and D2 is progressing. By consent, C1's claim against D3 was struck out with no order as to costs on 28 September 2017.

4. C2's claim proceeds against all three defendants. They apply to strike his claim out or have summary judgment entered in their favour, adopting each other's cases as set out in their applications, and in their written and oral submissions (with adaptations as necessary to reflect the differences between them as parties).

C2's Claim

5. C2's particulars of claim were dated 25 July 2017. They were amended on 19 July 2018. The following paragraphs are based on the facts as pleaded in the amended particulars, which facts I accept for present purposes.

6. C1 gave birth to a daughter at the Portland Hospital on 29 March 2011, by elective caesarean section. She was a private patient at that hospital. C1 was discharged on 1 April 2011 with her baby daughter. She was re-admitted to the Portland Hospital on 26 April 2011, again as a private patient, with a suspected infection of her caesarean wound.

7. Thereafter her mental health deteriorated. On 27 April 2011 she became anxious and distressed and tried to pull out her drain. She was put under observation every 15 minutes. On 28 April 2011, she was assessed by a psychiatric nurse. On 29 April 2011, she was seen by D2 who noted that she was suffering a mixed affective state with fluctuating orientation. D1 saw her on 30 April 2011 and noted that she appeared to be mentally stable. D2 saw her again on 1 May 2011 and noted that she continued to do well, although C2 maintains that C1 was by now delusional. On 3 May 2011, nursing staff noted that C1 was confused and agitated. On 4 May 2011, the notes record a discussion with C2 about statements made by C1, which included C1 saying that she had been visited by a Cameroonian gang leader, her life had been threatened, money had been stolen from her, and that the children were at home being cared for by a nanny. The note records C2 being concerned about his children's safety. Entries in the notes later that day record C1 having alleged that she was raped by her uncle when she was 3, that she had thoughts of hurting family members, and other assertions of a similar nature. She was assessed by D2 at 16.30, he concluded she was having an acute stress reaction and that some intervention from other agencies, including the police, was warranted.

8. It is C2's case that D2 told him that C1 was suffering a stress reaction to having visitors, who had threatened her; that she had recovered from a psychiatric episode, and was not ill; that her allegations were truthful; that there were child- protection issues for the police to consider.

9. The police came to interview C1 at around 17.30 hours that evening. She was later seen by D1 and D2. The notes record that referral to the local mental health team was being considered and that she was confused and restless. At 07.25 on 5 May 2011, C1 was violent to a mental health nurse, and then put her clothes on and said

she wanted to leave. She was discharged from hospital later that day, against C2's wishes. C2 took her by taxi to Islington Police Station where she was "sectioned".

10. It appears that after that, C1 was compulsorily detained in a psychiatric hospital for some weeks. C1 and C2 became estranged. C2 served an injunction on C1 preventing her from accessing her children. C1's condition subsequently stabilised and she was then reconciled with C2.

11. The essence of C2's claim is that D1, D2 and/or D3 provided negligent advice and / or incorrect information to C2, on which he relied, and which caused him to believe that C1's delusions were or may have been based in fact, which in turn caused him to doubt the basis of his relationship with C1, and to seek to protect his children from her. It is said that this failure caused C1 and C2 to separate and caused persisting problems in the family bonds and relationships, as well as financial loss and damage.

12. C2 brings his case in contract and tort. C1 was admitted to the Portland Hospital as a private patient, and C2 asserts that he was owed a duty in contract and in tort, which duty was breached by all three defendants, causing him to sustain loss and damage.

13. C2 has served a schedule of loss and damage. C2 claims general damages of £20,000. This is for injury to feelings or mental distress at the events complained of. The remainder of the claim is for past and future losses, including loss of income, predicated on C2's case that he was forced to give up his job and sell his house in Islington and move to Hampshire to look after his children. The quantum of the pleaded losses exceeds £2 million.

14. C2 has also served a response to a request for further information, in which he sets out further particulars about his case.

Claim in Contract

15. There is no doubt that a contract existed between C1 and D3 for the provision of healthcare to C1. On each occasion when C1 was admitted, a pro forma admission form was signed (on the first occasion by her, on the second occasion by C2 on her behalf) and counter-signed by a registration officer on behalf of C3. The terms and conditions refer to the "patient"; that is a clear reference to C1.

16. That admission form stated that the consultants (that is, in this case, D1 and D2) are independent practitioners, not employed by the hospital, who supply their services direct to the patient. D1 and D2 were not, therefore, party to the contract with D3. There is no written contract with either of D1 or D2, but Mr Walker submitted, and I accept for the purposes of argument, that a contract with each of D1 and D2 came into existence in relation to the treatment offered to C1 as their patient, at the moment that they offered to provide treatment to her and that offer was accepted by her.

17. The issue in the case is: did D1, D2 and D3 also contract with C2? C2 argues that each of them also, and separately, contracted with him; further, that the contract which each of them had with him was not merely a contract for payment, collateral to the contract each defendant entered into with C1, but was for services to be provided by each defendant to C2 "for his own health and welfare" (I quote from Mr Walker's

submissions – the content of the alleged contract is only very lightly sketched in the pleadings).

18. The case in contract is set out at [5]-[8] of the Amended Particulars of Claim. That claim is put in various ways: that the contract was partly oral and partly in writing, and related to advice paid for by C2 via his insurance policy, alternatively it is subject to implied terms under the Supply of Goods and Services Act 1982 and / or at common law to reflect business efficacy ([5]); that the contract was the consequence of D3's advertising that it provided a high standard of care and would provide peace of mind for patients and their families ([6]); that it was a collateral contract with implied terms that C2 would pay for C1's care in consideration of the defendants providing information and advice to C2 as well as C1 ([7]); that in the absence of a direct contract, C2 is entitled to pursue the defendants under s 1 of the Contract (Rights of Third Parties) Act 1999 ([8]).

19. In oral submissions, Mr Walker could not point to any written contract between any of the defendants and C2. (At one point, he seemed to assert that because C2 had signed the admission form on C1's behalf when she was readmitted on 26 April 2011, that brought such a contract into existence; but it is very clear that C2 was simply signing on behalf of C1, and that the admission form does not in and of itself bring into existence any contract between D3 and C2, a matter which Mr Walker seemed to accept.) Mr Walker did not suggest that any express words were used at any stage to create a contract between C2 and any of the defendants. Mr Walker focussed his argument on the proposition that the contract between C2 and each of D1, D2 and D3 came into existence by necessary implication, at a time unspecified, but before any one of them (D3 by its servants or agents) told C2 that C1 was not mentally ill (that being the misstatement relied on by C2 to mount his claim for consequential losses). Mr Walker was unable to give any further particulars of the contract or its timing: it was all a matter of necessary implication, he said. He did not press the point that the contract was a consequence of D3's advertising (this anyway would not help him in his case against D1 and D2) or that C2 had rights under the 1999 Act (which he plainly does not: he is not a named beneficiary under any contract, such as might entitle him to the benefit of such a contract as a third party). He concentrated on the general circumstances of this case, as a result of which, he argued, a contract necessarily came into existence between each of the defendants and C2.

20. I am not persuaded that a contract must be implied between C2 and each of D1, D2 and D3, related to his own health and welfare. Far from it being necessary in order to give business efficacy to the arrangements that such a contract should be implied, there are strong reasons for concluding of necessity the other way, that none of the defendants entered into a contract with C2 at any time in relation to his own health and welfare. First, any such contract would raise the obvious risk of conflict, in relation to duties of care and confidence already owed by each of the defendants to C1, who was their patient; she could, at any time, have asked any one of the defendants *not* to discuss her medical condition with C2 or disclose information to C2 about her or her condition – which would have frustrated any agreement between C2 and the defendants that C2 *should* be provided with such information to safeguard his own health and welfare. Secondly, such a contract would have been of potentially large scope and would have imposed additional liability on each of the defendants, bearing in mind that it is said to extend to financial losses consequent on the

defendants giving information that was wrong ; yet at no stage was there discussion about such an assumption of liability, and at no stage was there an offer of payment to the defendants to reflect the enlarged liability. Had such a discussion taken place, or a fee been offered, I have little doubt that each defendant would have declined to assume the additional contractual liability which was of uncertain nature and extensive scope. It would go against common sense and business efficacy to imply a contract between C2 and any of the defendants, relating to his own health and welfare and any financial loss consequent thereon. Such a contract simply did not exist, even arguably.

21. The matter is put beyond doubt by the decision of the Court of Appeal in *West Bromwich Albion FC v El Safty* [2007] PIQR P 7, in which Rix LJ rejected an argument similar to that advanced by C2 in this case: see [48].

22. I therefore reject the proposition that there was or could arguably have been a contract in existence at any stage between C2 and any one of D1, D2 or D3, relating to his own health and welfare. The arguments based on terms implied under the Supply of Goods and Services Act 1982, at common law or in response to advertising statements fall away in the absence of any contract. I am satisfied that C2's case, to the extent that it is based on the assertion of a contract between the defendants and C2, is bound to fail and must therefore be struck out under CPR 3.4(2)(a) as well as summary judgment being entered for the Defendants under CPR 24.2. It is hopeless.

Claim in Tort

23. I turn then to consider the case as it is brought in tort. C2 asserts at [4] of the Amended Particulars that such a duty of care existed. It is important to note that, so far as the claim is in tort, it is for pure economic loss. Although damages for mental distress may, in some circumstances, be recoverable in contract, it is common ground that they are not recoverable in tort. Therefore, the claim for general damages cannot succeed under the tort heading. The remaining claims are all for financial loss.

24. The defendants argue that C2's claim in tort cannot succeed, for a variety of reasons, but in the main because:

    i) C2 cannot show that the defendants owed him (as opposed to C1) any duty of care in tort which related to his own health and welfare and extended to protecting him against pure economic loss in the event of breach.

    ii) C2 cannot show, even taking his case at its highest on the evidence, that he would be able to establish his case in causation, namely that the negligent mis-statement caused him to suffer the loss of which he now complains.

Duty of Care

25. The criteria by which the existence and scope of a duty of care in tort are judged are set out in *Caparo Industries v Dickman* [1990] 2 AC 605 (see, in particular, passages at pp 617/8, 620/21 and 627), amongst other cases.

26. Mr Barnes, supported by Ms Campbell-Clause, argues that there is insufficient proximity here, and that in any event, economic loss was not a foreseeable

consequence of any negligent act or omission, and further, that to impose any such duty would not be fair, just and reasonable in the circumstances. Thus, they say, C2 fails on each limb of the tripartite test in *Caparo.*

27. Their submissions relied substantially on *West Bromwich Albion*, where the Court had considered an analogous situation where medical care was provided by an orthopaedic surgeon (Medhat El-Safty) to a footballer (Michael Appleton), the issue being whether the surgeon also owed a duty of care to the club for which Mr Appleton played, and which held the BUPA policy which would pay for Mr Appleton's medical treatment (WBA), it being argued by WBA that it was owed a duty to prevent it incurring foreseeable economic loss in the event that the footballer was unable to play as a result of negligent treatment provided by the surgeon. The Court of Appeal concluded that the surgeon did not owe the club any duty in tort (or contract). Rix LJ held, in passages with which Mummery LJ and Peter Smith J agreed, that:

> "57 … What has to be found is a duty of care owed by Mr El-Safty to WBA not to cause it financial loss.
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> 58 In my judgment, even if it be assumed that there was foreseeability by Mr El-Safty and reliance by WBA, none of the other necessary elements for liability was satisfied here.
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> 59 Thus, I do not consider that there was any assumption of responsibility here by Mr El-Safty to advise the Club. This case is quite unlike the typical case where an adviser knows that his advice will be relied on by third parties with relevant financial interests. The immediate interest here is medical, not financial.…
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> 60 For very much the same reasons, it seems to me that there is no reason to find here the proximity necessary to the creation of a duty of care. The dominant relationship is that of the doctor and his patient, and the dominant context is that of Mr Appleton's health, not his employer's financial security.
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> …
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> 63 So, here too, I would also hold that it would not be fair, just and equitable to impose liability for financial loss on Mr El-Safty in favour of WBA. If WBA had wanted Mr El-Safty's advice for the purposes of its own interests, it could have made that plain to him. He would then have been put in a position where he could choose to charge for that advice and the risks involved in giving it, and/or of disclaiming liability. …"

28. In answer, Mr Walker relied on two authorities. He suggested that *ABC v St George's Healthcare NHS Trust* [2017] EWCA Civ 336 favoured his case. In that case, the Court of Appeal allowed an appeal against a strike out at first instance, of the Claimant's claim based on the failure by hospital doctors to disclose to her that her father had been diagnosed with Huntingdon's disease in sufficient time for her to have the baby she was then carrying tested for the disease. The Claimant's claim was that the facts "gave rise to a special relationship between the Defendants and the

Claimant", alternatively that there was "an assumption of responsibility by the Defendants to the Claimant", either way giving rise to a duty of care for the Claimant's "welfare and psychological and/or physical well-being" (see [17]). The Court held that the Claimant was not bound to fail at trial (see [27]) and the case is continuing towards trial (so I was informed by Mr Barnes). There is, of course, an important difference between *ABC* and this case, because the duty of care in *ABC* was said to extend to the Claimant's own health and that of her unborn baby; the claim was not for pure economic loss occasioned by the Defendants' alleged failure to tell her that she might carry the gene for Huntingdon's disease. I am not therefore persuaded that *ABC* helps the Claimant given this important difference; in any event, it is a case limited to very specific facts (disclosure of a hereditary disease in a family member) which find no analogue in this case.

29. Secondly, Mr Walker relied on *Darnley v Croydon Health Services NHS Trust* [2018] UKSC 50, where the Supreme Court held that the duty of care owed by an NHS Trust extended to advice given by non-medical staff as well as medical staff (see [19]). However, that case does not assist him, because it involved negligent advice given to a patient. The issue in this case is whether C2, as a non-patient, was owed a duty of care by the hospital staff and by the doctors treating C1, she being the patient. *Darnley* deals with a different point entirely.

30. Mr Walker argued that this case lay at the cutting edge of the law and should not be stifled at the preliminary stage, simply because there had not been any previous case quite like it.

31. In my judgment, the defendants' submissions must prevail. It is very clear, applying well established principles, that no duty of care, let alone a duty to prevent economic loss, was owed by the defendants to C2. There was no assumption of responsibility by any one of the defendants at any time to protect C2 against economic loss, there was insufficient proximity between the defendants and C2 (who was simply the partner of the C1, the patient), and in any event it would not be fair, just and reasonable to impose a duty on the defendants. These points are all determined against C2 by *West Bromwich Albion*, a case on facts which are strongly analogous.

32. I do not accept that C2's claim is at the cutting edge or that it depends on resolving a point of legal uncertainty. To the contrary, the principles are well established: the hospital and doctors treating C1 did not owe C2 any duty, personal to him, to safeguard his welfare and health and to protect him from economic loss. Accordingly, his claim in tort must be struck out under CPR 3.4(2)(a) and/or summary judgment should be entered for the Defendants under CPR 24.2.

Causation

33. Mr Barnes for D3 further submits that, in any event, this claim is doomed to fail because C2 could not establish causation, even taking the facts at their most beneficial to C2. C2's case is set out in his Schedule which asserts that he suffered increased expenditure "caused by the above indication given by the second and first defendants and repeated by the officers of the third defendant, that the first defendant was not suffering from a psychiatric illness and was simply involved in criminal activity... the second claimant was obliged to give up his job, to care for the children and the family…"

34. This "indication" was given on 4 May 2011. It is the advice which C2 says was negligent and which forms the basis of this claim.

35. C1 was discharged from the Portland Hospital on the following day, 5 May 2011. C2 took her direct from hospital to Islington police station where she was detained under the Mental Health Act. C2 therefore knew or suspected within a very short time of the allegedly negligent advice that C1 was psychiatrically unwell. She remained an in-patient at a psychiatric hospital for some weeks, until 27 May 2011. It is during this time that C2 says he became estranged from her and started to incur the losses he now claims. (Those losses continued long after his wife was released from the psychiatric hospital, at which point the Amended Particulars suggest that the couple were reconciled: see [44]. The basis on which the claim continues beyond the point of her release, and/or the point of reconciliation between C1 and C2 is not at all clear to me.)

36. Mr Barnes suggests that in light of this history of events, and on C2's own case, C2 will not be able to establish at trial that the negligent advice (ie, that C1 was not ill but was making allegations which were true) caused C2 to sustain the losses which he claims, because it was very quickly apparent that C1 was ill, which must have led C2 to doubt the advice which C2 says he was given by the defendants (of which he now complains) to the effect that she was not ill but was involved in criminal activity, or to rely on that advice further. Ms Campbell-Clause adopts the same tack.

37. Mr Walker argues that C2 had been told that C1 was not ill, and any view expressed to contrary effect at the point that she was sectioned while at Islington Police Station was simply another professional view, which did not eradicate the earlier one; C2 had mixed information before him and he continued to rely on the earlier advice given by the defendants.

38. In my judgment, C2's case on causation is not tenable. Once C1 was sectioned under the Mental Health Act on 5 May 2011, any earlier advice which might have been given to the effect that she was not mentally ill, was quite clearly put in doubt. There is no real prospect of C2's causation case succeeding in light of the fact that C1 was sectioned within a very short time after the allegedly negligent advice was given. For that further reason I enter summary judgment for the Defendants on the claim in tort, pursuant to CPR 24.2. (I prefer to enter summary judgment on that basis, because I consider this part of C2's claim to be very weak on the facts, rather than bound to fail as a matter of law.)

CONCLUSION

39. Although Mr Walker suggested that it was premature to take a final view about the merits of any aspect of C2's claim, I am sure that no amendment to the pleaded case, further disclosure, or development of argument could save C2's case. It is bound to fail at trial for reasons I have set out above. I therefore allow the applications and strike C2's claim out under CPR 3.4(2)(a) and/or enter summary judgment for the Defendants under CPR 24.2.

40. I thank all counsel and their supporting legal teams for their assistance in resolving these applications.