Neutral Citation Number: [2015] EWHC 1394 (QB)

Case No: HQ13X04208

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 19/05/2015

Before :

MR JUSTICE NICOL

- -

Between :

ABC	**Claimant**
- and -	
(1) St George's Healthcare NHS Trust	**Defendants**
(2) South West London and St George's Mental Health NHS Trust	
(3) Sussex Partnership NHS Foundation Trust	

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Philip Havers QC and Hannah Noyce (instructed by **Capsticks**) for the **Defendants**
Elizabeth Anne Gumbel QC and Henry Witcomb (instructed by **Field Fisher**) for the **Claimant**

Hearing dates: 7th May 2015

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Judgment

Mr Justice Nicol :

1. The essential facts of this claim are short and tragic. In 2007 the Claimant's father ('F') shot and killed the Claimant's mother. He was convicted of manslaughter on grounds of diminished responsibility and sentenced to a Hospital Order under the Mental Health Act 1983 s.37 and made subject to a Restriction Order in accordance with s.41 of the same Act. He was detained at the Shaftesbury Clinic which is part of Springfield University Hospital which in turn is run by the Second Defendant. In 2009 it was suspected that he was suffering from Huntington's Disease and he was referred to St George's Hospital which is the responsibility of the First Defendant. While he was at the Shaftesbury Clinic he was also seen by a social worker who was employed by the Third Defendant. For present purposes I can refer to all three Defendants collectively. It is not necessary to distinguish between them. In November 2009 it was confirmed that F did indeed have Huntington's Disease.

2. Huntington's Disease is an extremely serious condition. It is also genetic in origin. If a parent has it, there is a 50% chance that his or her child will have it as well. For good reason therefore, the various health professionals sought F's consent to disclose the diagnosis to his daughter. As it happens, the Claimant was pregnant at this time. It

is pleaded that the Defendants were aware of this and aware that the Claimant would be very concerned about having a child who might also have Huntington's Disease. F refused to allow the medical staff to tell his daughter about this diagnosis. They did not do so and F's daughter ('C') was born in April 2010. In August 2010 the Claimant was told accidentally by one of her father's doctors that he had Huntington's Disease. In January 2013 the Claimant herself was diagnosed with the same condition. It is too early to tell whether C also has Huntington's Disease since it is not usual to test for it until adulthood. In her Amended Particulars of Claim the Claimant alleges that the failure to tell her of her father's condition was (a) actionable negligence on the part of the Defendants and (b) a violation of her rights under Article 8 of the European Convention on Human Rights. She pleads that if she had been informed of her father's condition, she would have undergone a test to see whether she had it as well. Once that showed positive, she would have terminated her pregnancy. She says she has suffered psychiatric damage because of the Defendant's failure to inform her, and, if her daughter does have the disease, the Claimant says she will also incur additional expense which would otherwise have been avoided.

3. The claim is at an early stage. The Claim Form has been issued and Particulars of Claim have been served. Draft Amendments to the Particulars have been proposed. The Defendants apply, however, to bring the claim to an end. They submit I should strike it out because it discloses no reasonable cause of action. They have also sought summary judgment but, Mr Havers QC on their behalf, accepted that this added nothing to the strike out application.

4. In short, Mr Havers submits that, even if all the factual allegations in the Draft Amended Particulars of Claim are proved, it is plain that the Claimant will not be able to establish a relevant duty of care on the part of the Defendants and she does not have an arguable claim that her rights under the Convention have been violated.

5. I need to add a little more detail from the pleadings (for simplicity I will refer to the Draft Amended Particulars of Claim as 'POC'). The Claimant and her sister from time to time attended the Springfield Clinic for family therapy. I can see from the medical records that this was suggested to F in January 2009. There was a meeting between a representative of the family therapy team, F and the Claimant in March 2009 and further meetings between the three of them in October, November and December 2009. The Claimant pleads as well that she attended multi-disciplinary meetings relating to her father's care. In August 2009 one of the doctors noted that F had said that he had told his brother of what would then have been a possible diagnosis of Huntington's Disease. There was discussion among the medical staff as to whether the Claimant should be told about the diagnosis (particularly in view of her pregnancy) but the prevailing view seems to have been that the confidentiality of the information should be respected and should not be overridden. The notes record that F "was concerned that his daughters should not be informed about the possibility of HD as he felt they might get upset, kill themselves or have an abortion." The notes record the professionals' concern as to the wisdom of his decision.

6. A person who is detained as F was must be discharged if a tribunal so orders. In the past the Tribunal in question was the Mental Health Review Tribunal. Now it is the First Tier Tribunal (Health Education and Social Care Chamber) Mental Health. On 5th August 2010 the Tribunal made a conditional order for F's discharge. On 9th December 2010 it confirmed that the conditions were in place and discharge could proceed on the previously specified conditions.

7. The Claimant placed considerable reliance on a report of a Joint Committee of the Royal College of Physicians, the Royal College of Pathologists and the British Society for Human Genetics. This was published in April 2006 and was entitled, "Consent and Confidentiality in Genetic Practice: Guidance on Genetic Testing and Sharing Genetic Information." One section of the report dealt with disclosure of information. At paragraph 2.5.3 the Report discussed the position where consent to release information had been refused. It said,

> "The Human Genetics Commission, the Nuffield Council on Bioethics and the GMC have all expressed the view that the rule of confidentiality is not absolute. In special circumstances it may be justified to break confidence where the aversion of harm by the disclosure substantially outweighs the patient's claim to confidentiality. Examples may include a person declining to inform relatives of a genetic risk of which they may be unaware, or to allow the release of information to allow specific genetic testing to be undertaken.
>
> Before disclosure is made in such circumstances, an attempt should be made to persuade the patient in question to consent to disclosure; the benefit to those at risk should be so considerable as to outweigh any distress which disclosure would cause the patient; and the information should be anonymised and restricted as far as possible to that which is strictly necessary for the communication of risk.
>
> We recommend that before disclosure is made when consent has been withheld, the situation should be discussed with professional colleagues and the reasons for disclosure documented. Current GMC guidance states that the individual should generally be informed before disclosing the information."

8. The reference to the GMC was to its report in 2004 on Confidentiality. Updated Guidance was published by the GMC in 2009. This identifies as one of the principles to be applied that,

> "Confidentiality is central to the trust between doctors and patients. Without assurances about confidentiality, patients may be reluctant to seek medical attention or to give doctors the information they need in order to provide good care. But appropriate information sharing is essential to the efficient provision of safe, effective care, both for the individual patient and for the wider community of patients."

9. The Guidance recognises that the duty of confidentiality is not absolute. Disclosure may, for instance, be permitted in the public interest. Under the heading, "Disclosure to Protect Others" the Guidance says,

> "Disclosure of personal information about a patient without consent may be justified in the public interest if failure to disclose may expose others to a risk of death or serious harm. You should still seek the patient's consent to disclosure if practicable and consider any reasons given for refusal.
>
> Such a situation might arise, for example, when a disclosure would be likely to assist in the prevention, detection or prosecution of serious crime, especially crimes against the person. When victims of violence refuse police assistance, disclosure may still be justified if others remain at risk, for example from someone who is prepared to use weapons, or from domestic violence when children or others may be at risk.

If a patient's refusal to consent to disclosure leaves others exposed to a risk so serious that it outweighs the patient's and the public interest in maintaining confidentiality, or if it is not practicable or safe to seek the patient's consent, you should disclose information promptly to an appropriate person or authority. You should inform the patient before disclosing the information, if practicable and safe, even if you intend to disclose without their consent."

10. It is convenient to address first the question as to whether the Claimant's claim in negligence should be struck out before considering the claim under the Convention.

The Defendants' submissions: negligence

11. Mr Havers referred to the familiar tripartite test of a duty of care in *Caparo v Dickman* [1990] 2 AC 605. For the purposes of the present application, the Defendants were prepared to proceed on the basis that the Claimant would be able to establish at trial that injury to her would have been reasonably foreseeable if they failed to inform her that her father had Huntington's Disease. Again, for the purposes of the present application, they were prepared to accept that there was sufficient proximity between the Claimant and the Defendants for a duty of care to arise. However, there was no reasonable prospect of the Claimant establishing that it would be fair, just or reasonable to impose on the Defendants a duty of care towards the Claimant in this regard.

12. Mr Havers emphasised that the Claimant was seeking to impose liability for an omission – a failure to inform her of her father's condition. Ordinarily that required either some special relationship between Claimant and Defendant or the Defendant assuming a responsibility for the care of the Claimant. Yet the present situation could not be characterised in either way. Furthermore, the Claimant was seeking to recover damages in a novel situation. Of course, the categories of duty of care were not closed. However, they should be expanded only incrementally. The Claimant could not point to any situation where a duty of care was recognised to exist which was at all comparable or close to the present one.

13. As the GMC Guidance stressed, it was very important that a patient should be able to rely on his or her doctor respecting the confidential character of the information which passed between them. The law recognised this by imposing a duty of confidence on the doctor. It was not absolute. The public interest in preserving confidence could, in certain circumstances, be outweighed by the public interest in disclosure, but that did not make it fair, just or reasonable, to impose a duty of care on the Defendants to the Claimant. Mr Havers advanced nine reasons why I should come to that conclusion.

i) What was put against the public interest in preserving confidence in the present context was not a public interest in disclosure, but the private interest of the Claimant.

ii) The law of confidence allowed a doctor to disclose confidential information in certain circumstances – see for instance *Attorney-General v Guardian Newspapers (No.2)* [1990] 2 AC 109 (and I would add *W v Egdell* [1990] Ch 359). The Claimant was contending for a duty to do so. Consciously or unconsciously, this might encourage doctors to breach confidence where it might not otherwise have been justified.

iii) Doctors would be subject to conflicting duties, liable to be sued by their patient if they disclose information which should have remained confidential,

liable to be sued by a third party, such as the Claimant, if they fail to disclose information which they should have revealed.

iv) If a doctor is subject to a duty of care in some situations to disclose information to third parties, it will undermine the trust and confidence which is so important to the doctor/patient relationship. It may lead to patients being less candid with their doctors. The same point had been made by the European Court of Human Rights in the context of Article 8 of the Convention – see *Z v Finland* (1998) 25 EHRR 371 at [95].

v) If doctors owed a duty of care to third parties, it may result in doctors putting pressure on their patients to agree to disclosure to avoid the risk of being sued by third parties.

vi) Some third parties may not wish to receive information. Yet a doctor may not be able to explore whether this is the case without effectively imparting the information itself.

vii) It is possible that the third party may suffer psychiatric harm if he or she is told the information in question. The doctor will be in a dilemma as to how to explore whether this is the case when the third party is not or may not be his or her patient.

viii) Doctors receive a very great deal of confidential information. It would be burdensome to place on them a duty to consider whether any of it needs to be disclosed to third parties. The time and resources committed to this will be a distraction from treating patients.

ix) This significant extension of a doctor's duty of care would be contrary to the incremental way in which the law of negligence ought to progress.

Claimant's submissions: negligence

14. Ms Gumbel QC for the Claimant reminded me of the caution with which I should approach an application to strike out a claim. Not only must I assume that the Claimant would be able to prove the facts pleaded in the PoC, but I should also not foreclose the possibility of her being able to establish a duty of care unless it was clear that this was doomed to failure. On many previous occasions the higher courts had lamented that the examination of whether a duty of care existed had been tested against hypothetically assumed facts rather than by reference to facts proved at trial. She also stressed that what mattered was whether this Claimant on these facts could establish a duty of care. I should not be diverted into resolving the precise limits that such a duty would entail.

15. Of particular importance in this case was the fact that F was a detained mental patient. The Claimant was not just any third party, but the Claimant's daughter. Issues such as the existence of a special relationship and the assumption of responsibility were usually important where there would not otherwise be a sufficiently proximate relationship between Claimant and Defendant. For the purpose of this application, however, the Defendant was prepared to accept that there was the necessary proximity between them. Furthermore, the Claimant herself had been undergoing family therapy with the Defendants. She was in that sense their patient, like her father. The purpose of the therapy was to help her come to terms with the fact that her father had killed her mother, but that was not possible if she was kept in ignorance of this aspect of her father's condition which may have been material in what had led him to do what he

had done. There was, she submitted, no proper assessment of her father's ability to make an informed decision as to whether it was right to withhold information about his diagnosis from her. In addition, the Claimant was in discussion with the doctors about her father's release into the community. F had told his brother about the diagnosis of Huntington's Disease. That may mean that the information was likely to get out anyway.

16. The Defendants recognised that a doctor was not always required to preserve patient confidentiality. The GMC Guidance contemplated that doctors would not simply be at liberty on occasions to disclose confidential information, but might be under a positive duty to do so. The duty of care for which the Claimant contended would not therefore be so novel a development as the Defendants submitted.

Negligence: Discussion

17. The Hospital and Restriction Orders to which F was subject clearly curtailed his liberty. For all practical purposes, he was not going to be discharged from hospital until the Tribunal determined that this was consistent with the protection of public safety. But in many important ways the relationship between him and the doctors who were treating him was the same as between any other doctor and patient. Thus, it was not disputed by the Claimant that the starting point was that the Defendants were obliged to respect the confidentiality of his medical information. Manifestly, this was a qualified duty. It could not, for instance, prevent the Defendants from reporting relevant matters to the Tribunal. They did disclose to the Tribunal the fact of F's diagnosis of Huntington's disease. It was thought this might have had some bearing on the killing of his wife. The Claimant was engaged in discussions with the medical staff about her father's discharge into the community. I cannot see, however, how that has any bearing on the current issue. The duty of care for which the Claimant contends was not in relation to her father's eventual discharge. That did not occur until December 2010. Her complaint is that she was not given information about his genetic condition in time for her to test herself and to terminate her pregnancy well prior to C's birth in April 2010.

18. F's conviction for manslaughter implied acceptance that he was (at least in 2007) suffering from a disease of the mind which diminished his responsibility for his criminal act. It did not mean that he lacked capacity to give or withhold his consent to his daughter being told of the diagnosis of Huntington's Disease. The Mental Capacity Act 2005 establishes the principles to be applied in that regard. Importantly, a person is assumed to have capacity until the contrary is established (2005 Act s.1(2)). Capacity is determined issue by issue (*ibid* s.2(1)). A person is not to be treated as unable to make a decision simply because he makes an unwise one (*ibid* s.1(4)). The Claimant does not plead that her father did lack capacity to make a decision that she should not be told of his diagnosis. In Ms Gumbel's written and oral submissions it was argued that the Defendants did not properly consider whether F was able to take informed decisions. However, this does not take the Claimant far enough absent an assertion (which is not made) that, if the issue had been examined, the Defendants would have realised F did not have capacity to instruct the doctors to withhold the information from his daughter.

19. It is of little importance that F had apparently told his brother of his condition. This did not strip the information of its confidential character. It could only be a matter of speculation as to whether this would lead to the information being circulated more widely and, it was not this but the accidental disclosure by one of the hospital doctors which led to the Claimant learning of the diagnosis.

20. One of the particulars of negligence is that the Defendants "failed to give proper advice and counselling to [F] so as to persuade him of the need for his daughters including the Claimant to be told of the diagnosis." I cannot, though, see how this assists the Claimant unless she were to assert (which she does not) that, if her father had been given this advice and counselling, he would have consented to the disclosure being made to her. The other particulars of negligence are steps along the way to the Claimant's primary case that the Defendants were negligent in not disclosing this information to her despite the absence of consent from her father.

21. Does it make a difference that the Claimant was undergoing family therapy with the Defendants? It has to be said that there was no reference to this in the original Particulars of Claim and, even with the proposed amendments, the references are scant and do little to explain its relevance. It did feature more prominently in Ms Gumbel's written and oral submissions. She argued that because the Defendants were encouraging the Claimant to take part in family therapy and because she had agreed to do so, there was a doctor / patient relationship between her and them. This also meant that her complaint was not just of an omission to act, but amounted to negligence in the way in which the family therapy was carried out.

22. Attractively as this was argued by Ms Gumbel, I am not persuaded that it significantly affects the viability of the Claimant's case that the Defendants owed her a relevant duty of care. The purpose of the family therapy was, as I have said, to help the whole family (and particularly the Claimant and her sister) come to terms with what had happened. I will assume for present purposes that F's Huntington's Disease was a contributory factor in his mental condition which led him to shoot his wife. It may well be that the Defendants owed the Claimant a duty of care in the way in which they carried out the family therapy. But none of this means that the Defendants were obliged to disclose to some family members information which they held under a duty of confidence to another family member. I do not accept that the claim can be characterised as badly performed family therapy rather than the omission to disclose information which the Claimant would have wanted to know.

23. In my judgment the duty of care which the Claimant is trying to construct is entirely novel. I asked Ms Gumbel what was the nearest situation in which a duty of care had been recognised. She referred me to *A v East Kent Hospitals University NHS Foundation Trust* [2015] EWHC 1038 (QB). In that case a mother who had been receiving ante-natal care from the defendant complained that she had not been told that her baby might be suffering from a chromosomal abnormality. If she had been so advised, she said she would have had an abortion.

24. However, this was an entirely conventional duty of care owed by a doctor to his patient. It was common ground that if there had been evidence at either of two ante-natal consultations of a material risk that the baby was suffering from chromosomal abnormality then this ought to have been disclosed to the Claimant. That is far removed from the duty of care which the Claimant needs to establish in the present case.

25. Ms Gumbel referred me as well to the case of *Angela P v St James and Seacroft University Hospital NHS Trust* [2001] EWCA Civ 560 where a sterilisation procedure had gone wrong and the woman concerned had given birth to a child with a disability. It was held that the hospital was liable for the costs of bringing up a disabled child, but not the costs which would have been incurred in bringing up a healthy child. This, too, however, is far removed from the present situation. In that case the Claimant was the doctor's patient. It was plain that he owed her a duty of

care. The debate revolved around its precise content and, in particular, whether it included duties in relation to the different economic losses which the Claimant had suffered. *Angela P* is not helpful in providing a springboard or stepping stone to the very different duty for which the Claimant in the present case contends.

26. On the other hand the Defendants pointed to authorities which strongly suggested that no such duty of care would be owed to the Claimant. In *Powell v Boladz* [1998] Lloyds Rep. Med. 116 CA the parents of a young boy who had been treated by the Defendant brought a claim in negligence. They alleged that certain documentary records of their son's treatment had been altered after his death and the realisation of this had caused the father psychiatric harm. The claim was struck out because, amongst other reasons, the doctor owed no duty of care to the parents. The duty of care was owed to the child, his patient and no other - see p.123. The Court of Appeal followed the decision of the House of Lords in *X v Bedfordshire County Council* [1995] 2 AC 633. In that case parents of children who had been taken into care following allegations of abuse brought claims in negligence against the local authorities involved on the grounds that the abuse assessments were carelessly made. The claims were struck out as disclosing no reasonable cause of action. The House of Lords confirmed that no duty of care was owed to the parents. Mr Havers relied on this as well for confirmation of the incremental approach to novel duties of care (see Lord Browne-Wilkinson at p.751) and for recognition of the danger of imposing duties of care which might lead to a defensive and cautious approach by public authorities (*ibid* at p.750). The claims of parents wrongly suspected of child abuse were again unsuccessful in *D v East Berkshire NHS Trust* [2005] 2 AC 373. Once again the parents' claims were struck out as disclosing no reasonable cause of action because no duty of care was owed to them. Considerable stress was laid on the danger of creating duties which could potentially conflict, exposing the doctor to a claim from the parent if he acted on his suspicion of abuse and from the child if he did not - see Lord Nicholls at [85], Lord Rodger at [110] and Lord Brown at [129] and [137].

27. In my judgment, therefore, this is not a case where the Claimant can show that a novel duty of care would be but an incremental development from some well established duty. It would, on the contrary, be a radical departure to impose liability in circumstances such as these. It would be an example of the "giant step" which Lord Toulson in *Michael v Chief Constable of the South Wales Police* [2015] UKSC 2 at [102] contrasted with the proper development of the common law of negligence by incremental steps.

28. While in some circumstances, it may be difficult to distinguish between negligence which takes the form of an omission, on the one hand, from careless positive action, on the other, I struggle to see how the Claimant's complaint can be characterised as anything other than an omission. The Claimant's involvement in family therapy provided by the Defendants may come closest to positive action by them. Yet still, on analysis, the complaint remains, as it is put in the PoC about what the Defendants did not do – they did not tell her about her father's condition. Whether that is actionable depends on whether they were under a duty to do so. There was no assumption of responsibility towards the Claimant in this regard and, even taking account of all the facts pleaded in the PoC, I do not accept Ms Gumbel's submission that there was a special relationship between the Defendants and the Claimant. I recognise that the search for a common principle uniting such relationships is somewhat elusive. In *Barrett v Ministry of Defence* [1995] 1 WLR 1217 Beldam LJ suggested at p.1224 that,

> "The characteristic which distinguishes those relationships is reliance expressed or implied in the relationship which the party to whom the duty is owed is entitled to place on the other to make provision for his safety."

Yet that does not begin to describe the relationship between the Claimant and the Defendants. There is nothing analogous in that to the situations where a special relationship has been found to exist, such as an occupier of land to neighbours, an employer to his employees, a parent or a school to a child. In *Barrett* itself the Court of Appeal held that the Army owed no duty to an off-duty serviceman to prevent him consuming excessive alcohol in the mess bar. In her skeleton argument, Ms Gumbel submitted "It would be very curious if the Defendants' clinicians were entitled to discuss the Claimant's pregnancy and the possibility she would have an abortion but not owe any duties to advise her as to the risks to her fetus of developing a genetic disorder." But in my judgment this juxtaposition does not strengthen the Claimant's contention. The clinicians were "entitled to discuss the Claimant's pregnancy and the possibility she would have an abortion" because on the pleaded facts she had made them aware of these matters. They were matters properly to be taken into account in the discussions they had with F and the advice that they gave to him. However, they fall well short of demonstrating that the Defendants owed a duty of care to the Claimant to disclose information about her father's diagnosis to her against the wishes of her father, their patient. Ordinarily, therefore, I accept the absence of a special relationship and the absence of assumption of responsibility mean that the Claimant cannot establish a duty of care.

29. Ms Gumbel is entitled to observe that the Defendants have been prepared to concede for the purpose of the present application that there was a sufficient degree of proximity for a duty of care to exist. Sometimes the existence of a special relationship or the assumption of responsibility is said to be important only because there is no such proximity. Whether that is so or not, Mr Havers, as I have indicated, submitted that it would not be fair, just or reasonable, to impose a duty of care of the kind contended for by the Claimant.

30. Ms Gumbel urged me to focus on the facts of the present case. She did so, presumably, to discourage me from being deflected by the wider implications which Mr Havers had argued would follow if there was a duty of care in the present case. Yet, unless there is some limiting principle inherent in the facts of the immediate case, a court must take into account the potential consequences of a new duty of care. I was not able to discern any such limiting principle in the Claimant's submissions and, while individually there may be scope for debate about Mr Havers' submissions, cumulatively they provide a formidable argument as to why it would not be fair, just or reasonable to find a duty of care of the type for which the Claimant contends.

31. There have, as Ms Gumbel submitted, been numerous warnings about the caution which must be exercised before striking out a claim at the pleadings stage – see for instance *X v Bedfordshire* (above) at p.740 and *Barrett v London Borough of Enfield* [2001] 2 AC 550, at 557. On the other hand, if it is plain and certain that the pleaded facts do not disclose a reasonable cause of action it is to the advantage of all concerned that the claim should not proceed to what would be a costly but inevitably fruitless trial – see *D v East Berkshire Community Health NHS Trust* (above) at [99]. I have reached the clear conclusion that that is how the Claimant's cause of action in negligence should be described. There is no reasonably arguable duty of care. The claim is bound to fail. It should be struck out.

The Human Rights claim

32. It is not unfair to characterise this part of the argument for the Claimant as an afterthought. The Claim Form alleges a claim in negligence. It makes no reference to the Convention. On the contrary, it is said in terms that the claim does not include any issues under the Human Rights Act 1998.

33. The PoC makes scant reference to this claim. It is alleged that

> "The failure of the First, Second and Third Defendants, their servants and agents to notify the Claimant of the diagnosis of her father and/or that she was at increased risk of inheriting the disease herself, which had a devastating effect on her own life was a breach of duty of care *and was contrary to the Claimant's rights under the Human Rights Act 1998.*" [my emphasis].

Towards the end of the pleading it is said,

> "Further the Claimant claims damages under the Human Rights Act 1998 for breach of Article 8 of the European Convention on Human Rights."
>
> That is all.

34. In her skeleton argument Ms Gumbel submitted that the Claimant's right to family life was obviously affected by the diagnosis of her father's condition. The Defendants were obliged to consider and weigh those interests against her father's right to have his confidentiality respected. The balancing of those interests could only be done at trial.

35. Mr Havers submitted that, even assuming Article 8 was engaged, any interference would plainly be justified under Article 8(2) for all of the reasons relied upon in answer to the common law claim. This afterthought on the Claimant's behalf therefore added nothing of substance.

36. Ms Gumbel argued that the Convention was relevant in two respects: it could inform the development of the common law and there were the independent rights under the Human Rights Act. The Claimant relied on both.

37. It has to be the Claimant's case that the positive duty implicit in Article 8 required the Defendants to disclose her father's condition to her. Only then could their failure constitute an interference with her rights under Article 8 (whether to her family life or, as I think is more accurate, her private life). It may not matter whether the debate is seen as taking place over the existence of such a positive duty or the justification for any interference. Either way there is plainly a balance to be struck between the value to the Claimant of knowing that her father had this genetic condition (and so that she had a 50% chance of also being afflicted) on the one hand and her father's right (also under Article 8) to have the confidentiality of his medical information preserved.

38. I agree with Mr Havers that all the reasons which I have set out in the context of the common law claim, mean that the balance comes down decisively against the Claimant. The Convention does not assist the Claimant in either of the ways she puts her case.

Conclusion

39. It follows that I accede to the Defendants' application. The claim is struck out.

Publicity

40. At the beginning of the hearing, Ms Gumbel applied for an order that the Claimant, her father and her daughter should be anonymised. Mr Havers was neutral in respect of that matter.

41. Ms Gumbel referred me to *JX MX v Dartford and Gravesham NHS Trust* [2015] EWCA Civ 96 and *A v East Kent Hospitals University NHS Foundation Trust* [2015] EWHC 1038 (QB) where the authorities, legislation and provisions of the Civil Procedure Rules are fully set out.

42. I recognised that the normal principle is that hearings should be conducted in public and be fully reportable. What was sought was a departure from this. Such a departure could, in principle, be justified in the interests of the administration of justice and/or by virtue of the Claimant's rights under Article 8 of the European Convention on Human Rights.

43. There were no members of the press present at the hearing. I was conscious that I should be particularly cautious about making an order affecting freedom of expression when there was no argument in opposition. Nonetheless, I considered that such an order was necessary and I granted it.

44. I briefly explain my reasons why. As is clear from the judgment above, the Claimant's father has been diagnosed with Huntington's Disease. This is a genetic condition. A sufferer's child has a 50% chance of inheriting it. The Claimant has subsequently discovered that she, too, has Huntington's Disease. It is her case that if she was given the information when she should have been, she would have terminated the baby she was then carrying. She was not. That child was born. It is her daughter. It is usual not to test a child for Huntington's Disease until she is an adult. The daughter does not at present know her mother has Huntington's Disease. The daughter does not know that she has a 50% chance of inheriting it herself. I accepted that there could be serious consequences for the daughter if she found out about these matters through a report of the present proceedings. This together with the rights of the Claimant and her daughter not to have their private lives interfered with by the action of the court, appeared to me to justify the restriction on publicity which the Claimant sought.

45. I should make clear that I was less impressed by Ms Gumbel's argument that it would be harmful for the Claimant's daughter if she were to learn through publicity of these proceedings that her grandfather had killed her grandmother. Sadly, such family killings are not unique. Normally, the suffering which is caused to family members cannot be allayed by restricting publicity of court proceedings.

46. I was moreover aware that there had been publicity at the time of the Claimant's father's trial. The order which I made included provision for service not only on the Press Association (by whom it may be distributed to their members) but to those publishers whom the Claimant was aware had written stories about the case in the past. The order, as is usual, included the opportunity for an application by the press to set aside or vary the restrictions which I imposed. If such an application is made, I will, of course, consider afresh whether they ought to continue.