IS THE UNEQUAL TREATMENT OF MATERNAL AND PATERNAL LIABILITY UNDER THE CONGENITAL DISABILITIES (CIVIL LIABILITY) ACT 1976 JUSTIFIED?

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ABSTRACT

Under the Congenital Disabilities (Civil Liability) Act 1976 (CDCLA) a child born disabled as a result of an occurrence prior to its birth can bring a claim against the individual responsible for that occurrence. Significantly, mothers are exempt from liability (except in relation to negligent driving) but fathers are not. Since the CDCLA came into force in 1976, there have been significant shifts in the landscape in which it operates: a more gender-neutral model of parenting; transmission of an infection to a sexual partner can be a criminal offence; and growing evidence regarding the impact of prenatal events. In addition, there is a trend for presenting prenatal harm as a problem of individual behaviour. This article presents a timely consideration of the potential for parental liability under the CDCLA and asks whether restricting the exemption of parental liability to mothers but not fathers can be justified. It is argued that the reasons for unequal parental liability in relation to gestational harm are not sufficient to justify restricting the broad exemption to mothers but not fathers and a change in the law is required to bring the CDCLA up to date with advances in the criminal law, society, and medical science.

KEYWORDS: Congenital Disabilities (Civil Liability) Act 1976, maternal liability, parental liability, paternal liability, wrongful life
I. INTRODUCTION
Under the Congenital Disabilities (Civil Liability) Act 1976 (CDCLA) a child born disabled as a result of an occurrence prior to its birth can bring a claim against the individual responsible for that occurrence. Significantly, mothers are exempt from liability under the CDCLA (except in relation to negligent driving) but fathers are not. Since the CDCLA came into force in 1976, there have been significant shifts in the landscape in which it operates: the move towards an acceptance of a more gender-neutral model of parenting; non-disclosure of a sexually transmitted infection to a sexual partner can now be the basis of a criminal offence; and there is growing evidence regarding the impact of prenatal events on future children. In addition, there is a growing trend for presenting prenatal harm as a problem of individual behaviour. This article presents a timely consideration of the potential for parental liability under the CDCLA and asks whether restricting the exemption of parental liability to mothers but not fathers can be justified in light of these shifts.

The arguments in favour of the unequal treatment of maternal and paternal liability differ depending on the timing of the event. Therefore, it is necessary to distinguish between three categories of events which could lead to liability under the CDCLA; those that occur prior to conception (pre-conception harm), those that occur at the time of conception (conception harm) and those that occur during pregnancy or birth (gestational harm). I will consider each of these in turn to establish precisely how the liability of mothers and fathers is unequal under the CDCLA before considering whether such an inequality is justified. This will lead me to conclude that while there are reasons for treating paternal and maternal liability differently in relation to gestational harm these are not sufficient to justify restricting the broad exemption to mothers but not fathers. Therefore, a change in the law is required to bring the CDCLA up to date with advances in the criminal law, society, and medical science.

II. LIABILITY UNDER THE CDCLA
The CDCLA was brought into law following the thalidomide tragedy to provide compensation for a child born alive suffering disabilities as a result of either, an occurrence prior to conception which affected either parent’s ability to have a healthy child, an occurrence affecting the mother during pregnancy, or one affecting the mother or child during its birth. Any such liability under the CDCLA is dependent on a breach of legal duty owed to the parent although there is no requirement that the affected parent is harmed themselves. In this way, although the claim is brought by the child, it reflects liability for harm done to the parent’s ability to have a healthy child. For example, if a doctor fails to warn a pregnant woman of a risk associated with a caesarean

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1 In the context of this article, I use ‘father’ to refer to the genetic father or sperm donor and ‘mother’ and ‘pregnant woman’ to refer to the genetic mother and gestator. I acknowledge that not all sperm donors or pregnant people will identify with these terms.

2 Emily Jackson, *Regulating Reproduction: Law, Technology and Autonomy* (Hart Publishing 2001) 151–59; Catherine Bowden, ‘Are We Justified in Introducing Carbon Monoxide Testing to Encourage Smoking Cessation in Pregnant Women?’ [2019] 27(2) Health Care Anal 128.

3 See Harvey Teff and Colin R Munro, *Thalidomide: The Legal Aftermath* (Saxon House 1976).

4 CDCLA, s 1.

5 CDCLA, s 1(3).
section and that risk materialises causing the child to be born disabled, whether that child can bring a claim against the doctor will depend on whether the risk was one which the doctor had a duty to warn the woman of. If there was no duty to warn the woman of that risk the child will have no claim. Crucially, the CDCLA provides an exemption for harm due to the actions of the child’s mother, other than for injuries caused by negligent driving. Therefore, a child cannot sue its mother for harm suffered as a result of her conduct before or during pregnancy, or her choices regarding delivery. There is no equivalent exemption for paternal conduct.

Before I can consider whether the unequal treatment of maternal and paternal liability under the CDCLA is justified, I must first establish that the treatment is unequal by demonstrating that paternal liability is a possibility where maternal liability is not.

A. Is Paternal Liability Possible where Maternal Liability is Not?
Under the CDCLA, section 1(1), the child’s mother is excluded from liability under the Act but there is no parallel provision excluding fathers from liability. Although fathers are not included in the exemption under CDCLA, section 1(1) this might not amount to unequal treatment if paternal liability is not possible for another reason. Indeed, in 1997 Margaret Brazier argued that the exclusion of maternal but not paternal liability under the CDCLA was justified in part because the construction of the CDCLA meant that liability for either parent was extremely unlikely even without the exclusion. This is supported by the lack of claims against fathers since the CDCLA has been in force. However, since then there have been significant developments in medical science and in the law on the duty to warn sexual partners of sexually transmissible infections which mean that paternal liability might not be as unlikely as it once was. If this is the case, paternal liability would be possible under the Act where maternal liability is not. In order to establish the potential for paternal liability under the CDCLA I will consider parental liability for gestational, pre-conception, and conception harm separately.

B. Gestational Harm
The construction of the CDCLA means that liability of either parent for gestational harm is only possible in very limited circumstances even without the maternal exclusion in section 1(1). As explained above, the CDCLA does not create a duty of care,

6 The question of whether the risk falls within the scope of the doctor’s duty to warn will be decided by applying the principle in Montgomery v Lanarkshire [2015] UKSC 11 discussed below.
7 CDCLA, s 2. As a policy decision the maternal exemption does not apply to liability in relation to negligent driving as such liability would be covered by motor insurance which is a legal requirement for all drivers. Law Commission, Injuries to Unborn Children (Law Com No 60, 1974) para 60.
8 The CDCLA does take some account of the potential for maternal responsibility in that in a case where a child is suing a third party such as the mother’s doctor in relation to an injury suffered prenatally, under CDCLA, s 1(7) the child’s damages may be reduced if the mother contributed to the disability. As Brazier and Cave note, this provision envisages cases where a pregnant mother contributes to the child’s disability by smoking, drinking, or failing to take precautions, against medical advice. M Brazier and E Cave, Medicine, Patients and the Law (6th edn, Manchester University Press 2016) 344.
9 Margaret Brazier, ‘Parental Responsibilities: Foetal Welfare and Children’s Health’ in C Bridge (ed), Family Law Towards the Millennium: Essays for P M Bromley (Butterworth-Heinemann Ltd 1997).
10 Except for liability in relation to negligent driving by the mother which does not depend on a duty of care to the affected parent.
it merely extends any existing duty of care owed to the affected parent to also provide a cause of action for the child born disabled as a result of the defendant’s actions. Therefore, any liability of a mother to her child would be dependent on her already owing a duty of care to the child’s father which, if breached, could affect his ability to have a healthy child (the mother could not owe a duty of care to herself) and vice versa.

Without the exclusion in CDCLA, section 1(1) maternal liability for gestational harm might be possible under the Act. For example, if the pregnant woman was the father’s employer she would owe him a duty of care as his employer, and she could breach this duty by having an unsafe work environment (perhaps stress or exposure to a toxin). Even if this does not harm the father, if it harms her future child that child could potentially claim against the mother for disability if the maternal exemption was not in place. It is questionable whether this would count as having affected the father’s ability to have ‘a normal, healthy child’ as the harm is occurring through the pregnant woman’s body and so it may be the mother rather than the father who is considered to be the affected parent. However, it could be argued that the pregnant woman’s breach of duty towards him has prevented him having the normal, healthy child he otherwise would. Even if technically possible, such liability seems highly unlikely particularly as the child would be able to claim against the company employing his father rather than the mother as an individual. If maternal liability for gestational harm is at most a remote possibility even without the exclusion in section 1(1), the exclusion has little impact on liability in relation to gestational harm.

What about paternal liability for gestational harm? As the CDCLA does not create a new duty of care, paternal liability is dependent on the father owing an existing duty of care to the pregnant woman or otherwise being liable to her in tort. Perhaps, the clearest example of this is where a father commits an intentional tort such as a battery against his pregnant partner. In this case, the father would be liable to the mother in tort and so would be liable to the child under the CDCLA for any disabilities it was subsequently born suffering from as a result of the battery.

Is paternal liability for negligent gestational events possible under the CDCLA? For example, if a man regularly smokes in the home he shares with his pregnant partner, knowing that there is a risk to the health of his partner and the future child, could this be a breach of a duty of care in negligence? The existence of a duty of care would most likely depend on the three-part test set out by the House of Lords in the case of Caparo v Dickman: (i) damage must be reasonably foreseeable as a result of the defendant’s conduct; (ii) the parties must be in a relationship of proximity or neighbourhood; and (iii) it must be considered fair, just, and reasonable to impose liability. The first two requirements are likely to be satisfied as first, it is foreseeable that the woman could suffer harm from the effects of passive smoking as this is a known

11 CDCLA, s 2(a).
12 Brazier (n 9) 275.
13 [1990] UKHL 2 [1990] 2 AC 605; This was confirmed as the relevant test for novel scenarios in which there is no established duty of care in negligence in the case of Robinson v Chief Constable of West Yorkshire Police [2018] UKSC 4.
risk, and secondly, there is likely to be sufficient legal proximity as there is a close relationship between the father and his pregnant partner which could be argued to be a relationship of some responsibility. However, even if these requirements are met, there are strong arguments against imposing liability on the basis that it would not be fair, just, and reasonable. Interfering with an individual’s conduct in the privacy of their own home requires a high degree of justification, and it is difficult to see what would be gained from litigation in these circumstances. In addition, the partner has some degree of choice over whether smoking is permitted in the home and/or whether she remains in the same room as her partner when he smokes or not. Further, even if a duty of care were held to exist, liability under the CDCLA would still be unlikely as the mother (the affected parent) would be likely to have been aware of the risk and viewed as having chosen to accept that risk in all but exceptional circumstances.

Therefore, in relation to gestational events, it seems that the only significant potential for paternal liability is where the father’s conduct represents an intentional tort such as a battery against the pregnant woman. As any liability pregnant women could have faced for gestational harm is excluded under the CDCLA, we can conclude that there is unequal treatment of mothers and fathers in relation to gestational harm under the CDCLA.

C. Pre-Conception Harm

There is a growing body of medical science demonstrating the impact of the pre-conception behaviour of both men and women on the health of their future offspring. Fathers are not exempt from liability under the CDCLA for pre-conception conduct such as smoking or drug taking which damages their own gametes leading to their future children being born disabled. However, such liability is unlikely as this would require the man to owe a duty of care to his sexual partner, or even his future sexual partner, to tailor his conduct in order to safeguard her ability to have healthy

14 The NHS website states that ‘Secondhand smoke is dangerous, especially for children. The best way to protect loved ones is to quit smoking. At the very least, make sure you have a smokefree home and car...Pregnant women exposed to passive smoke are more prone to premature birth and their baby is more at risk of low birthweight and cot death.’ NHS, ‘Passive Smoking’<https://www.nhs.uk/live-well/quit-smoking/passive-smoking-protect-your-family-and-friends/> accessed 20 May 2021.

15 Many of these arguments apply to paternal liability in general and are discussed below.

16 Imposing liability on an individual for smoking in their own home could also raise human rights issues. The smoker might argue that such liability interferes with his right to respect for home and private life under art 8 of the European Convention on Human Rights as given effect by the Human Rights Act 1998. However, this would have to be balanced against the claimant’s art 8 rights to not be exposed to smoke. For a consideration of the case law on this point, see John Coggon, ‘Public Health, Responsibility and English Law: Are There Such Things as No Smoke without IRE or Needless Clean Needles’ [2009] 17 Med L Rev 127; Neil Allen, ‘A Human Right to Smoke?’ [2008] 158 New Law J 886; Yvette van der Eijk and Gerard Porter, ‘Human Rights and Ethical Considerations for a Tobacco-Free Generation’ [2015] 24(3) Tob Control 238.

17 CDCLA, s 1(4).

18 For example, Kathleen Abu-Saad and Drora Fraser, ‘Maternal Nutrition and Birth Outcomes’ [2010] 32(1) Epidemiol Rev 5; Jonathan Day and others, ‘Influence of Paternal Preconception Exposures on Their Offspring: Through Epigenetics to Phenotype’ [2016] 5(1) Stem Cells 11; D Savitz, P Schwingl and M Keels, ‘Influence of Paternal Age, Smoking, and Alcohol Consumption on Congenital Anomalies’ [1991] 44(4) Teratology 429.
children. It is highly improbable that the law would ever consider it fair, just, and reasonable to impose such a duty given the extreme interference with individual liberty this would represent.¹⁹ For example, such a duty might hold a man liable for taking a job as a research scientist in nuclear energy (with the risk of exposure to radiation and damage to his sperm) decades before he had either contemplated fathering a child or met the woman with whom he would have a child. The improbability of such a duty of care existing in relation to pre-conception harm at the gamete stage means that the lack of paternal immunity under the CDCLA does not represent unequal treatment in any meaningful way in relation to pre-conception harm.

D. Conception Harm (Failure-to-Warn)
A more problematic way in which unequal treatment arises under the CDCLA is in relation to cases involving a duty to warn a sexual partner of risks such as sexually transmitted infections such as Human Immunodeficiency Virus (HIV) prior to them having unprotected sexual intercourse. If there were such a duty and the risk was not disclosed, any resulting child that is born HIV positive could have a potential claim against him under the CDCLA.²¹

At the time that the CDCLA came into force liability based on such a duty was unlikely on two grounds. First, it had not been considered a criminal offence for an individual to infect a sexual partner with HIV having failed to inform that partner of his HIV positive status and so it was unclear whether a duty existed to disclose HIV status to a sexual partner in the civil law of negligence. This has since changed with the criminal case of R v Dica.²² Secondly, it was possible that claims by a child under the CDCLA would be excluded as wrongful life claims following the ruling in McKay v Essex.²³ However, both of these grounds have shifted, making paternal liability under the CDCLA more likely.

1. Is there a duty to disclose HIV status to a sexual partner?
In the criminal case of R v Dica,²⁴ Dica was convicted of two counts of inflicting grievous bodily harm contrary to Offences Against the Person Act 1861 (OAPA), section 20 after he infected his lovers with HIV. The Court of Appeal held that the transmission of an infection can amount to the infliction of harm for the purposes of OAPA, sections 18 and 20 and that consent to sexual intercourse should not be regarded as consent to the risk of consequent disease.²⁵ The lack of consent to the risk of contracting HIV did not vitiate the consent to the sexual intercourse so that the charge is one of rape. However, this did not preclude a conviction for inflicting serious bodily

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¹⁹ Brazier (n 9) 275–76.
²⁰ Although there are evidential issues in proving causation in such cases—see for example, Reay v British Nuclear Fuels Plc [1993] 10 WLUK 71.
²¹ Brazier (n 9) and Catherine Stanton, ‘Genetic Transmission of Disease: A Legal Harm?’ 24 [2016] Health Care Anal 228, 240–41.
²² [2004] EWCA Crim 1103, [2004] QB 1257.
²³ [1982] 1 QB 1166, [1982] 2 All ER 771; Brazier (n 9) 276.
²⁴ R v Dica (n 22).
²⁵ ibid [59].
harm as an assault is no longer required for this offence; it simply requires that serious harm is inflicted on the victim without her consent.\footnote{This reasoning has been followed in cases such as \textit{R v Golding} [2014] EWCA Crim 889 and \textit{R v Konzani} [2005] EWCA Crim 706. Cases such as \textit{Assange v Sweden} [2011] EWHC 2849 (Admin), \textit{R(F) v DPP} [2013] EWHC 945 (Admin), [2014] QB 581 and \textit{McNally} [2013] EWCA Crim 1051 re-opened the question of whether non-disclosure could invalidate consent for the purposes of sexual offences; however, it seems likely that non-disclosure of HIV would not invalidate consent as it does not alter the nature of the act as discussed in Law Commission, \textit{Reform of Offences Against the Person} (Law Com No 361, 2015) 157–59.}

The reasoning in \textit{R v Dica}\footnote{\textit{R v Dica} (n 22).} falls short of making it a criminal offence to fail to disclose one’s HIV status to a sexual partner as it is the transmission of the infection that founds a conviction under OAPA, section 20, not the failure to disclose the risk; a conviction is only possible if the infection has in fact been passed on following the failure to disclose the risk. However, the judgment in \textit{R v Dica}\footnote{ibid.} can be used to make a strong argument that a duty of care to disclose material risks to sexual partners should be recognised in the civil law of negligence.

As explained above, a duty of care in negligence can be established in a novel scenario by applying the requirements set out in \textit{Caparo v Dickman}.\footnote{[1990] UKHL 2.} The requirements of foreseeability of harm and legal proximity between the claimant and the defendant are likely to be satisfied as it is known that HIV can be transmitted via unprotected sexual intercourse and there is a close connection between the claimant and defendant who have assumed some responsibility towards each other by becoming sexual partners.\footnote{As argued by Stanton in relation to a duty to warn sexual partners of genetic risks, Stanton (n 21).} It seems likely that such a duty would be considered fair, just, and reasonable as following \textit{R v Dica},\footnote{\textit{R v Dica} (n 22).} a breach of such duty could lead to criminal liability if the infection is passed on.

It could be argued that the current lack of civil claims indicates that a civil duty of care between sexual partners is unlikely to ever be more than hypothetical. However, there are several reasons to believe that such a duty is a real possibility. First, as I argue below, the landscape in which the law operates has shifted due to developments in societal norms, the criminal law, and medical science, meaning that the current lack of cases is not guaranteed to continue. Secondly, civil liability between sexual partners is a reality in other jurisdictions such as the USA\footnote{Lane Powell PC, ‘Liability for Transmission of HIV and Other Sexually Transmitted Diseases in Washington’ (Lexology, 5 May 2011) <https://www.lexology.com/library/detail.aspx?g=617851df-13a5-4e31-9d81-2773c133f75e> accessed 28 March 2022; Adam Liptak, ‘People Who Pass on AIDS Virus may be Sued’ (\textit{New York Times}, 4 July 2006) <https://www.nytimes.com/2006/07/04/health/people-who-pass-on-aids-virus-may-be-sued.html> accessed 28 March 2022; Neil Shouse, ‘Can I Sue Someone for Giving Me Herpes?’ (Shouse Injury Law Group, 8 July 2021) <https://www.shouselaw.com/ca/blog/personal-injury/can-i-sue-someone-for-giving-me-herpes/> accessed 28 March 2022.} and Canada.\footnote{Anna Matas, ‘Liability and the Sexually Transmitted Disease’ \textit{The Lawyers Weekly} (7 February 2014) <https://lernerpersonalinjury.ca/wp-content/uploads/Liability-and-the-sexually-transmitted-disease.pdf> accessed 28 March 2022.} Thirdly, some law firms in the UK are already indicating in their promotional material that civil claims
against partners for transmission of HIV could be possible.\(^{34}\) Fourthly, an absence of reported claims does not necessarily mean that no claims have been made; it is possible that claims have settled out of court. Therefore, a civil law duty to warn sexual partners of material risks seems a real possibility.\(^{35}\)

The parameters of the duty to warn in a medical context might provide a useful model for determining what would count as a ‘material risk’ to be disclosed between sexual partners. The case of \textit{Montgomery v Lanarkshire}\(^{36}\) established that in a medical context a risk is material if:

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\ldots\text{in the circumstances of the particular case, a reasonable person in the patient’s position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.}^{37}\]

It seems reasonable to suggest that an individual should have a duty to inform a sexual partner of risks which a reasonable person in the partner’s position would attach significance to, or that the individual is or should be reasonably aware that the particular partner would be likely to attach significance to. Basing the duty on this model would take account the seriousness of an HIV infection, the likelihood of transmission, and any particular concerns of the particular partner. This would not necessarily support a blanket duty to inform a sexual partner of a HIV-positive status: for example, if the individual was taking medication and was frequently tested showing a minimal viral load and condoms were being used. However, given the potential seriousness of an HIV infection, it would support a duty of care to inform a sexual partner of HIV-positive status if the risk was more than minimal or that partner had expressed a concern regarding contracting HIV.\(^{38}\)

If there were a duty of care in negligence to disclose risks of serious infections to sexual partners, liability under the CDCLA could exist even where the infection is not passed on to the sexual partner. This is because it is possible for the infection to be passed from the father to the child without the mother being infected.\(^{39}\) If the defendant (‘D’) failed to disclose his HIV status to the victim (V) but the infection was not in fact transmitted, it is likely that D owed V a duty of care to disclose and D breached

\(^{34}\) Cohen Cramer Solicitors, ‘Catching a Sexually Transmitted Disease’ \(<https://www.cohencramerpi.co.uk/cica-claims/claims-for-victims-of-rape-and-sexual-assault/claim-for-sexually-transmitted-disease/>\) accessed 28 March 2022; Katie Allard, ‘HIV – Still a Death Sentence?’ (\textit{Kingsley Napley}, 20 November 2015) \(<https://www.kingsleynapley.co.uk/insights/blogs/medical-negligence-and-personal-injury-blog/hiv-still-a-death-sentence/>\) accessed 28 March 2022.

\(^{35}\) Margaret Brazier cites the case of \textit{Shepherd v Davies} (1 November 1989, unreported) in support of a duty of care between sexual partners but I have not been able to find details of this case. Brazier (n 9) 276.

\(^{36}\) [2015] UKSC 11.

\(^{37}\) ibid [87].

\(^{38}\) For a discussion of how the varying levels of risk and definitions of sexual partners might affect a duty to disclose risks to sexual partners (pre \textit{R v Dica} see Rebecca Bennett, Heather Draper and Lucy Frith, ‘Ignorance Is Bliss? HIV and Moral Duties and Legal Duties to Forewarn’ [2000] 26(1) \textit{J Med Ethics} 9.

\(^{39}\) S Murugan and R Anburajan, ‘Father to Child Transmission of Human Immunodeficiency Virus Disease while Sero-Discordant Status of the Mother Is Maintained’ [2013] 34(1) \textit{Indian J Sex Transm Dis AIDS} 60.
that duty. There would be no causation of any recoverable loss to V. Therefore, V’s claim in negligence would fail. However, that would be no barrier to a subsequent child born disabled as a result of that failure to disclose bringing a claim against D under the CDCLA. Therefore, following R v Dica, it seems likely that a duty to disclose HIV status to a sexual partner would be recognised in negligence.

2. Would Such Claims be Prohibited as Claims for Wrongful Life?

The second reason that at the time the CDCLA was passed it was unlikely that a child could bring a claim based on a duty to disclose risks of sexually transmitted infection such as HIV, is the potential for such a claim to be prohibited as a claim for wrongful life. Medical science at the time was such that in these circumstances the only way for that child to not have been born suffering from HIV was for her conception not to have taken place and her not to have been born at all. In the view of the Court of Appeal in McKay v Essex AHA, such claims lie outside the scope of the CDCLA as the aim of the CDCLA is to compensate children born with disabilities which would not otherwise have been present. However, following the recent case of Toombes v Mitchell, it is no longer clear that such claims would be prohibited and even if they were prohibited, the treatment options now available mean that non-existence is no longer the only way of avoiding the harm.

3. Toombes v Mitchell

The question of how the prohibition on claims for wrongful life impacts on claims under CDCLA, section 1(2)(a) was considered in the recent case of Toombes v Mitchell. The claimant in this case had been born with a neural tube defect causing spinal cord tethering resulting in limited mobility and double incontinence. She alleged that her disability was caused by her mother’s failure to take folic acid supplements prior to her conception as a result of her general practitioner’s failure to advise her of the benefits of such supplements. It was the claimant’s contention that but-for the Defendant GP’s failure to advise her mother of the benefits of folic acid, her mother would have delayed attempting to conceive until she had increased her folic acid levels and therefore the claimant would not have been born. Any child that would have been subsequently conceived would have been a genetically different person to the claimant. The issue for the Court was whether such a claim for wrongful conception and birth represents a lawful cause of action under the CDCLA. The Court drew a distinction between claims involving an occurrence during pregnancy under CDCLA, section 1(2)(b) and claims under section 1(2)(a) which deals with preconception occurrences. CDCLA, section 1(2)(b) carries the rider ‘so that the child is

40 R v Dica (n 22).
41 McKay v Essex (n 23).
42 See J Fortin, ‘Is the “Wrongful Life” Action Really Dead?’ [1987] 9 J Soc Welfare L 306.
43 [2020] EWHC 3506 (QB).
44 ibid.
45 ibid.
born with disabilities which would not otherwise have been present’ which the Explanatory Note to the draft Bill explains as follows:

the clause gives the child no right of action for ‘wrongful life’ [...] Subsection (2)(b) is so worded as to import the assumption that, but for the occurrence giving rise to a disabled birth, the child would have been born normal and healthy (not that it would not have been born at all).46

However, section 1(2)(a) relating to preconception occurrences does not contain this rider and so does not prohibit claims by children who, but for the wrongful act, would never have been conceived. In relation to preconception occurrences Lambert J stated that:

...all that a claimant must prove to come within the Act is a wrongful act or omission leading to an occurrence (as defined) which results in a child who is born with disabilities. Unlike in a post-conception case, there is no need for the claimant to prove that, but for the wrongful act, he or she would still have been born. It is sufficient that the claimant was, in fact, born with a disability resulting from the occurrence.47

On this basis Lambert J held that sexual intercourse without the protective benefit of folic acid supplementation was a relevant occurrence for the purpose of section 1(2)(a) and therefore, a claim such as this, based on the assertion that the conception itself had harmed the claimant, was valid.48 This is supported by the Law Commission’s opinion that a child’s claim based on her father’s failure to inform her mother that he was infected with a sexually transmissible disease prior to sexual intercourse would not amount to a claim for wrongful life. In the Law Commission’s opinion:

Where the disabilities with which a child is born are actually caused by the sexual intercourse which results in his conception we do not think that any action he may have for such disabilities is properly called a ‘wrongful life’ action. It is not for being born that he seeks a remedy but for compensation for the disability resulting from the sexual intercourse. If that sexual intercourse and consequent disability can be shown to have resulted from the fault of another, then we do not think that the child should be without a remedy.49

Therefore, claims based on the mother’s assertion that had she been informed of the father’s HIV status she would not have had unprotected sexual intercourse with him, would appear not to be prohibited as claims for wrongful life.

46 CDCLA (n 7) [6].
47 Toombes v Mitchell (n 43) [53].
48 ibid [46]–[48].
49 CDCLA (n 7) [88].
A different view was taken by Lord Justice Henderson in the Court of Appeal in Criminal Injuries Compensation Authority v First-tier Tribunal and Y (CICA v F-tT and Y)\textsuperscript{50} for the purposes of a claim under the Criminal Injuries Compensation Scheme. Henderson LJ was of the opinion that for an injury to have taken place the individual must have previously existed (albeit as an embryo or foetus) in an uninjured state. In his opinion, a claim in relation to conception harm was a claim for wrongful existence and as such was not one for which compensation could be assessed as held in McKay v Essex.\textsuperscript{51}

If claims based on the mother’s assertion that had she been informed of the father’s HIV status she would not have had unprotected sexual intercourse with him at all were not barred as claims for wrongful life; it is also possible that claims based on the mother’s assertion that had she been informed of the father’s HIV status she would have not had unprotected sexual intercourse with him \textit{at that time}, but would have on another occasion to which the same risk would attach, could also succeed. Causation could be established on a similar basis to that in Chester v Afshar.\textsuperscript{52} The risk of the resulting child being infected would be unaffected by the failure to warn (as in Chester) and that risk would be less than 50% at any time.\textsuperscript{53} Therefore, but-for the failure to warn, on the balance of probabilities the harm would not have occurred and the principle in Chester could be applied to establish legal causation.\textsuperscript{54} Factual causation does not fail because the claimant \textit{could} still have suffered the same harm on another occasion, but only if the claimant \textit{would} have suffered the harm, on the balance of possibilities.\textsuperscript{55} However, subsequent cases have confined the principle in Chester to its particular circumstances,\textsuperscript{56} and so it is not clear if the argument in Chester could be relied upon to establish causation beyond a failure to warn of a risk of a treatment scenario.

Lambert J justified limiting the classification of prohibited wrongful life claims to those involving post-conception occurrences and not pre-conception occurrences on

\textsuperscript{50} [2017] EWCA Civ 139.
\textsuperscript{51} ibid [31].
\textsuperscript{52} [2004] UKHL 41.
\textsuperscript{53} Prior to interventions, the risk in Europe of vertical transmission (parent to child) of HIV was approxi-
mately 20% and with interventions this is reduced to about 1%. L Sherr and N Barry (2004) ‘Fatherhood and HIV-Positive Heterosexual Men’ 5 [2004] HIV Med 258, 260.
\textsuperscript{54} As explained by the Court of Appeal in Duce v Worcestershire Acute Hospitals NHS Trust [2018] EWCA Civ 1307 [56–58], factual causation had been established in Chester on a traditional ‘but-for’ basis. The claimant faced a 2% chance of the harm occurring on the day she had the procedure. If she had the procedure on another day she would have faced the same 2% risk. Therefore, if she had been warned of the risk and so had the procedure on another day, the chance that she would have still suffered the harm is only 2%. This means that on the balance of probabilities, but-for the failure-to-warn, her harm would not have occurred. Thus, factual causation was established. The question in Chester was one of legal causation, ie whether the fact that if warned of the risk the claimant would still have had the procedure but on a different day, made the loss too remote to be recoverable at law. In Chester, it was held that in order to uphold the claimant’s right to autonomy and dignity, legal causation was established. Chester (n 52) [24], Lord Steyn.
\textsuperscript{55} T Clark and D Nolan, ‘A Critique of Chester v Afshar’ 34(4) [2014] Oxf J Leg Stud 664.
\textsuperscript{56} Duce (n 54); Beary v Pall Mall Investments [2005] PNLR 35; Meiklejohn v St George’s Healthcare NHS Trust [2014] EWCA Civ 120; Correia v University Hospital of North Staffordshire NHS Trust [2017] EWCA Civ 356; Shaw v Kovac [2017] 1 WLR 4773.
the basis that post-conception occurrences engage social and moral policy issues in a unique way:

A negligent failure to prevent the birth of an already conceived child engages a range of social and moral policy issues, not least the imposition upon the medical profession of a duty to advise abortion in possibly dubious circumstances. However, claims based upon a wrongful act before conception which leads to the intercourse and conception raise no such difficulties.

Thus, a distinction is drawn between claims in which the child says it would have been better if her mother had aborted her pregnancy, and claims in which the child says that it would have been better if her mother had not conceived her. Given that in both of these scenarios the alternative for the child is non-existence and the mother could bring a claim for wrongful birth in either scenario, it is not clear why this distinction should be relevant from the child’s perspective.

The interpretation of CDCLA, section 1(2)(a) in this case appears to be reflecting the role of the CDCLA in protecting the reproductive health of the parent. What was central to the decision in *Toombes* was the fact that but-for the defendant’s negligence, the claimant’s mother could have had a healthy child; it did not matter whether the claimant could have been a healthy child. However, as we will see, it is not clear whether it is sufficient that the mother could have had a healthy child with another partner or whether it is necessary that that couple could have conceived a healthy child together.

Lambert J illustrates this point with the example of a couple who conceive a child following negligent advice regarding their genetic status and that child is born suffering from an inherited genetic condition. It is Lambert J’s assertion that such a child would have no claim under the CDCLA as there would be ‘...no circumstances affecting the intercourse in which a healthy child could have been conceived and no causal connection between the occurrence and the disability.’ This differs from the scenario in *Toombes*, as in that case the claimant’s mother would have been more likely to conceive a healthy child with the same partner at a later date after having increased her folic acid levels, whereas the couple in Lambert J’s example could not improve their chances of conceiving a healthy child together at any time even if they had been accurately informed of their genetic status, and it is this that it is alleged would bar the child’s claim. However, in the case of sexually transmitted infections such as HIV, if the mother states that had she been informed of the risk of HIV infection she would not have had unprotected intercourse with the father there are no circumstances in which a healthy child could have been conceived between that couple (as is the case for the couple in Lambert J’s example). The mother could have conceived a

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57 *Toombes v Mitchell* n 43 [52].
58 ibid.
59 ibid [55].
60 Unless the mother states that she would not have had unprotected intercourse with the father but they would have attempted to conceive with the assistance of fertility treatment including sperm washing, which can reduce the chances of transmission of HIV infection. V Savasi and others, ‘Safety of Sperm Washing and ART Outcome in 741 HIV-1-Serodiscordant Couples’ [2007] 22(3) Hum Reprod 772.
healthy child but would not have done so with that partner. It is not clear from the discussion in Toombes\(^61\) whether that is sufficient for a claim under CDCLA, section 1(2)(a) or whether it is necessary that the couple could have conceived a healthy child together at another time.

Lambert J’s example could be distinct from a case involving a sexually transmitted infection such as HIV if that example was limited to the scenario in which any child of either parent would inherit the genetic condition as opposed to only children that they conceived together. If the couple receiving genetic counselling were both wrongly informed that they did not carry a gene for an inheritable condition when in fact any child that either parent conceived would inherit that condition, then the negligent advice has not affected the parent’s ability to have a healthy child and so would not satisfy CDCLA, section 1(2)(a). However, in the case of a father’s failure to warn of his HIV status, the mother could have had a healthy child with another partner and so her ability to have a healthy child has been affected by the father’s breach of his duty to warn. In this case, what matters for pre-conception occurrences is whether but-for the breach of duty the mother could have had a healthy child even if this would have been with another partner.

It appears that the interpretation of CDCLA, section 1(2)(a) and its interaction with the bar on claims for wrongful life is not yet fully resolved but it is clear that the CDCLA was intended to cover claims by children born disabled after having been conceived in circumstances where the father does not disclose that he has a sexually transmitted infection to his sexual partner.\(^62\) In relation to HIV, such a claim may no longer need to be on the basis that the claimant should not have been conceived but could instead be brought on the basis of a missed opportunity for treatment.

4. Missed Opportunity for Treatment

Due to developments in medical science, treatment options to prevent the infection passing to the future child are now available if the HIV-positive status of the father is known.\(^63\) Therefore, a child’s claim based on her father’s failure to inform her mother of his HIV-positive status prior to sexual intercourse would no longer need to be a claim for wrongful conception and birth. Instead, it could be for the claimant’s disability which could have been avoided but-for the father’s breach of his duty to inform his sexual partner that he was infected with a sexually transmissible disease. This would also remove the need for the claimant to show that her mother would not have consented to sexual intercourse had she been informed of the risk.

The child’s claim could be based on the assertion that if the father had informed the mother of his HIV status, his mother would have still consented to having unprotected sexual intercourse with him but she would have then sought treatment to prevent the infection from passing to the future child. Treatments such as antiretroviral therapy (ART), appropriate management of delivery, and avoidance of breastfeeding

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61 Toombes v Mitchell (n 43).
62 Law Commission, Explanatory Notes to the Draft Bill (n 7), 47 para 5.
63 Claire L Townsend and others, ‘Low Rates of Mother-To-Child Transmission of HIV Following Effective Pregnancy Interventions in the United Kingdom and Ireland, 2000–2006’ [2008] 22 AIDS 973.
have been shown to reduce transmission rates from mother to child to 1–2%. Some studies indicate even lower transmission rates from women on ART for at least the last 14 days of pregnancy, with each additional week of treatment corresponding to a 10% reduction in the risk of transmission. This means that if the mother had been warned of the father’s HIV status, and she would have sought treatment, it is more likely than not that the child’s harm would have been prevented. Therefore, it seems likely that a child would have a valid claim under the CDCLA on the basis of a failure by the father to warn the mother of the risk of a sexually transmitted infection such as HIV, if three things were established: (i) that the mother would still have consented to the sexual intercourse; (ii) she would have then sought treatment to prevent the infection passing to the child; and (iii) that treatment would have had a greater than 50% chance of preventing the infection passing to the child.

It could be argued that a child’s claim under the CDCLA against her father based on his failure to warn his sexual partner of his HIV status would fail on the basis that the mother was aware that having unprotected sexual intercourse carries a risk of HIV infection for her and any resulting future child and she chose to accept that risk. However, this argument is unlikely to succeed as even if the mother was aware of a general risk, without being informed of her partner’s HIV status she cannot be said to have been aware of the actual risk she was taking.

Given the likelihood of a duty of care to warn sexual partners of significant infection risks following the case of *R v Dica* and the availability of highly effective treatments to prevent vertical transmission of HIV and the possibility that treatment might not be sought without knowledge of the HIV status of the parents, paternal liability for conception harm is a real possibility. However, maternal liability for conception harm is excluded under CDCLA, section 1(1). Therefore, paternal and maternal liability is unequal under the CDCLA.

### III. IS THE UNEQUAL TREATMENT OF MOTHERS AND FATHERS JUSTIFIED?

Maternal liability under the CDCLA was originally excluded due to fears that the mother would not have the funds to meet any award without causing hardship to the rest of the family, the parental bond between mother and disabled child would be

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64 European Collaborative Study, ‘HIV-Infected Pregnant Women and Vertical Transmission in Europe since 1986’ [2001] 15 AIDS 761; European Collaborative Study, ‘Mother-to-Child Transmission of HIV Infection in the Era of Highly Active Antiretroviral Therapy’ [2005] 40 Clin Infect Dis 458; ER Cooper and others, ‘Combination Antiretroviral Strategies for the Treatment of Pregnant HIV-1-Infected Women and Prevention of Perinatal HIV-1 Transmission’ [2002] 29 J Acquir Immune Defic Syndr 484; Centers for Disease Control and Prevention, ‘Achievements in Public Health. Reduction in Perinatal Transmission of HIV Infection–United States, 1985–2005’ [2006] 55 MMWR Morb Mortal Wkly Rep 592.

65 Townsend and others (n 63).

66 It is possible that a claim could be successful even if there was a less than 50% chance of the treatment preventing the infection passing to the child following the departure from usual causation principles in *Chester v Afshar* (n 52), although this would have to take into account subsequent case law such as *Duce v Worcestershire Acute Hospitals NHS Trust* (n 54), which has sought to limit the scope of this departure.

67 CDCLA, s 1(4).

68 *R v Dica* (n 22) [59].

69 ibid.
disturbed, and a legal action, or the threat of one, could be used as a weapon by fathers against mothers in custody disputes.\textsuperscript{70} At that time the Law Commission did not believe that these dangers warranted an exclusion of paternal liability.\textsuperscript{71} As Collier and Sheldon have argued, it was the mother’s familial role that was thought to require protection as it was assumed that mothers would be the primary carers for their children and fathers the breadwinners.\textsuperscript{72} Since then, there has been a significant shift towards a more gender-neutral model of parenting adopted in law and policy, moving away from the father as breadwinner model and acknowledging fatherhood as including a role of care.\textsuperscript{73} There has also been a shift in the experience of fatherhood since the 1970s. The time that British fathers spend in primary care has increased by 15–20 min each decade since the 1970s and paternal care in 2015 was equal to the amount of maternal care in the 1960s.\textsuperscript{74} However, the gap between the time investment of mothers and fathers in caring for children has increased.\textsuperscript{75} While childcare remains highly gendered, with the majority of the responsibility still falling to women,\textsuperscript{76} a shift has taken place in the decades since the CDCLA came into force, at least in the perception of what the roles of mothers and fathers should be. According to the British Social Attitudes survey, in 1987, 48\% of people supported a gendered separation of roles, with the woman as the primary carer and the father as the breadwinner, but this has declined to just 13\% in 2012.\textsuperscript{77} However, this has not translated into a more equal distribution of familial roles between mothers and fathers in practice, and one possible explanation for this is a ‘structural lag’ whereby societal institutions such as parental leave, childcare, and employment, have not yet caught up with the changes in women’s roles, significantly in paid employment.\textsuperscript{78} Instead of lagging behind these societal changes, there is an opportunity here for the CDCLA to contribute to the reconceptualising of reproduction and childrearing as a shared enterprise. Somewhat paradoxically, by extending the exclusion of liability under the CDCLA to fathers, the law could support the move towards fathers bearing more of the responsibility in reproduction and childrearing; instead of reinforcing the view that reproduction and childrearing is and should be ‘women’s business’, the law would be acknowledging the importance of the father–child bond and the acceptance of male single-parent families. Therefore, it appears that the Law Commission’s reasons for excluding maternal liability could now also be seen as justifying an exclusion of paternal liability in order to support the move towards a more gender-neutral model of parenting.

\begin{thebibliography}{99}
\bibitem{70} Law Commission (n 7) [54]–[64].
\bibitem{71} ibid [92].
\bibitem{72} R Collier and S Sheldon, Fragmenting Fatherhood: A Socio-Legal Study (Bloomsbury Publishing 2008) 56.
\bibitem{73} ibid 101–37.
\bibitem{74} E Altintas (2016) ‘Are British Parents Investing Less Time in Their Children? Centre for Social Investigation Briefing Note 27’ (Oxford Nuffield College) <http://csi.nuff.ox.ac.uk/wp-content/uploads/2016/09/CSI-27-Are-British-Parents-investing-less-time.pdf> accessed 19 November 2021.
\bibitem{75} ibid.
\bibitem{76} In 2012, men reported spending an average of 10 h a week looking after family members, while women reported spending an average of 23 h a week. A Park and others (eds) ‘British Social Attitudes: The 30th Report’ (London, NatCen Social Research 2013) 126 <https://www.bsa.natcen.ac.uk/media/38457/bsa30_gender_roles_final.pdf> accessed 19 November 2021.
\bibitem{77} ibid 119.
\bibitem{78} ibid 134.
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An underlying reason for the Act’s exemption of maternal but not paternal liability is the concern that maternal liability has the potential to conflict with abortion law; how can a woman be liable for causing harm to her foetus but not for destroying it? As Brazier points out, this is a perceived rather than an actual conflict as it is possible that a woman could owe a duty of care to a future child that she intends to bring to birth, but be permitted to abort a foetus she does not intend to bring to birth. The subject of her duty of care is the child that will exist in the future rather than the foetus that currently exists. No such conflict would be perceived in relation to paternal liability as a man has no power to request an abortion. However, the desire to avoid a perceived rather than real conflict does not seem to justify the unequal treatment of mothers and fathers under the CDCLA.

Paternal immunity was considered by the Law Commission but ultimately rejected for several reasons. First, a father’s conduct was not thought to be able to affect the future child to the same extent as the mother’s and so paternal liability would not lead to the same extreme surveillance of men’s lives as it would women’s. While this is likely to be true in terms of gestational events, there is growing scientific evidence that a man’s behaviour can lead to pre-gestational harm to a future child in the same way as a woman’s. Everything from how much he smokes and how much alcohol he consumes, to how much stress he experiences and what he eats, can all have an impact on the health of his future child. Similarly, although a pregnant woman has a unique physical connection to the future child, a father’s behaviour during the pregnancy can still have a significant impact on the health of that future child, for example, smoking in the home, domestic violence, or creating a stressful environment for the pregnant woman. Therefore, paternal liability, particularly in relation to pre-gestational harm, could lead to extreme surveillance of men’s lives. However, it is notable that, despite the Law Commission’s efforts to protect women from extreme surveillance, women’s behaviour is subject to increasing surveillance in the name of protecting future children, in a way that men’s behaviour is not. Evidence that a man’s conduct can affect the health of his future child has been substantial for decades and as yet the surveillance of pre-gestational conduct remains focused on women as the potential cause of prenatal harm. The view that women rather than men are almost exclusively the cause of prenatal harm to men is not simply a matter of biology but instead relies heavily on ideas of gender. This is clearly evident in the parliamentary debates leading to the

79 Brazier (n 9) 269.
80 ibid 270.
81 Law Commission (n 7) [92].
82 Jonathan Day and others (n 18); Savitz, Schwingl and Keels (n 18).
83 For example, BM Donovan and others, ‘Intimate Partner Violence during Pregnancy and the Risk for Adverse Infant Outcomes: A Systematic Review and Meta-Analysis’ [2016] 123 BJOG 1289; Lijuan Zhao and others, ‘Parental Smoking and the Risk of Congenital Heart Defects in Offspring: An Updated Meta-Analysis of Observational Studies’ [2020] 27 Eur J Prev Cardiol 1284.
84 For example, the recent policies to screen all pregnant women for carbon monoxide and alcohol consumption. Bowden (n 2); Ellie Lee and others, ‘Beyond “the Choice to Drink” in a UK Guideline on FASD: The Precautionary Principle, Pregnancy Surveillance, and the Managed Woman’ [2021] 24 Health, Risk & Society 17.
85 Sally Sheldon, ‘Reconceiving Masculinity: Imagining Men’s Reproductive Bodies in Law’ [1999] 2 J Law Soc 129, 132.
CDCLA in which the dangers posed by male bodies were conceptualised as occupational, and those posed by female bodies were associated with individual ‘choices’ such as drugs and alcohol. Cynthia Daniels connects this to four ideals of reproductive masculinity: the assumption that men are secondary in biological reproduction, the assumption that the male reproductive system is less vulnerable than the female reproductive system to the harms of the outside world, the assumption of male virility, and the presumption that men are more distant (than women) to the children they father. As Daniels argues, these ideals are not only harmful to women because they are more likely to be blamed for prenatal harm than men, but they are also harmful for men because little attention is paid to developing safe workplace regulations to protect men’s reproductive health. Rather than reinforcing this harmful ideal of masculinity and relying on it to protect men from surveillance, the CDCLA could acknowledge the potential for men’s behaviour to impact on future children and so avoid contributing to the conflict view of pregnancy by posing pregnant women as a unique threat to future children.

The Law Commission argued that because the potential allegations of paternal harm were more limited than those of maternal harm it was far less likely that legal action under the CDCLA would be used as a weapon in matrimonial disputes against fathers than against mothers. Given our enhanced understanding of the impact of paternal behaviour on the health of future children and the desire to move towards a more gender-neutral model of parenting discussed above, it seems that if the potential use in custody disputes is sufficient to justify the exclusion of maternal liability it could also justify an exclusion of paternal liability.

Another reason given by the Law Commission for not extending the exclusion of liability to fathers was that the father of the child might not be the husband of the mother and so any legislation excluding fathers from liability could lead to ‘very bizarre litigation’. Any problems defining who counts as the child’s father could be overcome by limiting father to genetic father in relation to pre-conception harm and those individuals (regardless of gender) who go on to have parental responsibility for gestational harm. Applying an exclusion on the basis of these definitions would avoid the scrutiny of men’s lives linked to harmful lifestyle factors and avoid the harm to the parental bond in relation to those who go on to have parental responsibility for the child. In any event, this is a problem the law deals with in many circumstances and is no more problematic for fathers than mothers given the potential for surrogacy arrangements, gamete donors, trans parents, and other non-traditional definitions of parent. Therefore, any difficulties in defining father do not justify the unequal treatment of mothers and fathers under the CDCLA.

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86 ibid 141–42.
87 Cynthia Daniels, *Exposing Men: The Science and Politics of Male Reproduction* (Oxford University Press 2008); See also Sheldon (n 85).
88 Daniels (n 86) ch 5.
89 Law Commission (n 7) [92].
90 ibid. It is assumed that what the Law Commission was referring to was the possibility that a child may not be able to bring a claim against her biological father with whom she may not have a loving bond but she could bring a claim against her social father with whom she does.
In the Law Commission’s opinion, the conclusive justification for not extending the exemption to fathers was the desire to permit a child born disabled as a result of an assault by her father on her mother to bring a claim against her father in respect of those disabilities:

We are also of the opinion that [...] a child born disabled as a result of an assault by a man on the mother should have a cause of action against that man, even though it was the assault itself which caused the conception.\(^91\)

Although this would include assaults at the pregnancy stage (see below), the Law Commission’s main concern appears to have been the scenario, whereby a child is born disabled having been conceived in circumstances in which her father did not disclose to his sexual partner that he was suffering from a sexually transmissible disease. It is clear from the Law Commission’s consideration of the example of a man who does not inform his sexual partner that he is infected with syphilis that this is what is meant by the Law Commission’s reference to ‘an assault which causes the conception’.\(^92\) Although this would no longer be termed an assault,\(^93\) it could still constitute a civil wrong in the form of a breach of a duty to warn as explained above.

If a man is under a duty of care to warn his sexual partner of the risk of transmission of an infection such as HIV and he breaches this duty, it seems entirely in keeping with the purpose of the CDCLA for him to be liable to any subsequent child born disabled whose disabilities would have been avoided if the father had fulfilled his duty of care to the mother. After all, this is merely extending his liability to the affected parent to include liability to the child born disabled as a result of his breach.\(^94\) However, if this is the case, it is not clear why it would be inappropriate for mothers to face similar liability under the CDCLA for a failure to warn their sexual partners of their disease status. The possibility of a woman committing a civil wrong against her sexual partner by not informing him that she is infected with a sexually transmissible disease was not considered by the Law Commission. A woman (presumably) owes the same duty to inform her sexual partner of her HIV positive status. If she breaches that duty and a child is born with HIV, the father could argue that had he been informed of her status, even if he would still have had unprotected sexual intercourse with her, he would have made medical staff aware and sought treatment for the child at least immediately following birth (treatment during pregnancy may not have been something he could have arranged on the balance of probabilities as the woman would have been unlikely to consent given that she did not seek treatment herself).\(^95\) Alternatively, if, as suggested by the judgment in Toombes,\(^96\) a claim can be brought under CDCLA,

\(^{91}\) Law Commission (n 7) [92].
\(^{92}\) ibid [88], [92], [93].
\(^{93}\) R v Dica (n 22) [47].
\(^{94}\) Brazier (n 9).
\(^{95}\) Treatment of the child after birth can be highly effective in reducing signs of the virus resulting in less damage to the immune system. Pilar Garcia-Broncano and others, ‘Early Antiretroviral Therapy in Neonates with HIV-1 Infection Restricts Viral Reservoir Size and Induces a Distinct Innate Immune Profile’ [2019] 11(520) Sci Transl Med eaa7350.
\(^{96}\) Matas (n 33).
section 1(2)(a) on the basis that the affected parent would have had a child with another partner if he had been informed of her status, the child could argue that the father would not have consented to sexual intercourse and so she would not have been conceived. If this is the case, exempting mothers from liability arising out of a failure to warn her sexual partner of the risk of transmission of a sexually transmitted infection but retaining such liability for fathers does not appear to be justified. Either it is appropriate for a parent to be liable to a child born disabled as a result of that failure to warn, or it is not.

A. Gestational Harm

Although, as explained above, a woman can commit an equivalent wrong in relation to pre-gestational harm, there is no equivalent maternal conduct during pregnancy to the man that commits a battery against a pregnant woman; any intentional violence by the pregnant woman that caused harm to the future child would be directed at her own body. This might appear to justify the unequal liability of mothers and fathers. However, this is one specific type of conduct and does not necessarily justify retaining liability for all forms of paternal conduct. Further, retaining paternal liability for gestational harm might not be necessary as other forms of redress might be available to a child whose congenital disabilities are caused by violence against the mother during pregnancy. In particular, in these circumstances, it may be possible for a child to be compensated by the Criminal Injuries Compensation Authority.

B. Is CICA Compensation Available in Relation to Harm In Utero?

The Criminal Injuries Compensation Scheme (the Scheme) provides compensation to those who have sustained a criminal injury which is directly attributable to their being a direct victim of a crime of violence. Although a foetus lacks legal personhood, it does have some protection under the criminal law and so a child who suffered harm at the foetal stage may be able to be considered a victim of a crime of violence. Indeed, under the earlier versions of the Scheme children born with Foetal Alcohol Spectrum Disorder were compensated as victims of their mothers’ drinking during pregnancy. In addition, Annex B to the 2012 Scheme states that:

4. (1) A crime of violence will not be considered to have been committed for the purposes of this Scheme if, in particular, an injury:

[e] was sustained in utero as a result of harmful substances willingly ingested by the mother during pregnancy, with intent to cause, or being reckless as to, injury to the foetus.

97 Criminal Injuries Compensation Scheme 2012, para 4.
98 For example, under OAPA, ss 58 and 59; Infant Life Preservation Act 1929, s 1.
99 CP (A Child) v First-tier Tribunal (Criminal Injuries Compensation) (CA) [2014] EWCA Civ 1554 [3] (Treacy LJ).
100 Criminal Injuries Compensation Scheme 2012, Annex B <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/808343/criminal-injuries-compensation-scheme-2012.pdf> accessed 5 August 2021.
Significantly, this implies that other forms of harm sustained in utero such as from an attack on the pregnant woman can be compensated.\footnote{There does not appear to be any data available as to whether any awards have been made on this basis; however, there is some anecdotal evidence that it has not. For example, Nick McCarthy, ‘Stabbed Mum’s Unborn Baby Is Refused Criminal Injuries Compensation’ Birmingham Mail (24 November 2016) <https://www.birminghammail.co.uk/news/midlands-news/stabbed-mums-unborn-baby-refused-12225378> accessed 5 August 2021.}

The Court of Appeal considered the possibility of a child being compensated for a crime against her mother that occurred prior to her birth in the case of \textit{CICA v F-TT and Y}.\footnote{\textit{CICA v F-TT and Y} (n 50).} In this case, Y had been born suffering from a serious genetic disorder after being conceived by incestuous rape. Initially, the claim for compensation was refused and this refusal was upheld by the First-tier tribunal on the grounds that Y was not a victim of a crime of violence and he had never had an uninjured state as it was the crime that had led to his conception. An application for judicial review was heard by the Upper Tribunal which granted compensation, finding that Y had suffered injuries which were directly attributable to a crime of violence within the meaning of paragraph 8 of the 2008 scheme which was applicable at the time.\footnote{\textit{Y v First-tier Tribunal and Criminal Injuries Compensation Authority} [2016] UKUT 0202 (AAC) 2, JR/2930/2014.} \textit{CICA} appealed the decision of the Upper Tribunal to the Court of Appeal which upheld the appeal, refusing Y compensation because Y had not been conceived at the time of the crime as it was the crime itself that led to Y’s conception and so he could not be considered a victim of a crime of violence and there was no ‘uninjured state’ with which to compare the child’s current state for the purposes of assessing compensation.\footnote{\textit{CICA v F-TT and Y} (n 50) [26].} In the case of an attack on the pregnant woman, this problem would not arise as the child would have been conceived prior to the attack and so there is an ‘uninjured state’ with which to compare the child’s current state. Therefore, it seems likely that a child born disabled as a result of her father committing a battery against her mother during pregnancy could be compensated under the Scheme.

An award under the Scheme is likely to be less than the damages available in a civil claim with claims under the Scheme capped at £500,000 and the vast majority of claims being substantially less than that.\footnote{Criminal Injuries Compensation Scheme [31]; \textit{Criminal Injuries Compensation Calculator} <https://criminal-injuries-compensation.co.uk/how-much-compensation-will-i-receive/> accessed 5 August 2021.} However, the levels of compensation could be increased if the level of redress available to the child was the concern rather than the source of that redress.

Because of this potential for redress under the Scheme and the option to limit paternal liability under the CDCLA to intentional torts against the mother during pregnancy, the desire to provide redress to the child born disabled as a result of her father committing a battery against her mother during pregnancy does not justify retaining all paternal liability under the CDCLA while mothers are exempt except in relation to negligent driving.
IV. CONCLUSION

Liability of either parent under the CDCLA might be unlikely due to the dependence on a duty of care owed to the affected parent but such liability is possible particularly in relation to failure to disclose risks to sexual partners. Mothers are protected from such liability by virtue of the exemption in section 1(1) CDCLA but fathers are not. This inequality in treatment is not justified by the outdated view of how parental roles should be split between the genders, the danger of liability under the CDCLA being used in matrimonial disputes, the practical difficulties in defining fathers, nor the desire for redress for a child born disabled as a result of an attack by her father on her mother during pregnancy.

While there is a case for permitting a child to claim against its father for intentional harm such as an attack on the mother during pregnancy, this could be argued to be unnecessary as the child could instead be compensated by CICA for this harm. Given that a child harmed in this way would not be without redress, retaining paternal (but not maternal) liability to cover such scenarios does not justify the resulting unequal liability for pre-gestational harm such as the failure to warn of risks between sexual partners. At most, it would justify making an exception to a paternal exemption to cover intentional torts against the pregnant woman.

The solution largely depends on whether it is desirable for a child born disabled as a result of her parent’s failure to warn their sexual partner of their HIV status to be able to bring a claim against that parent under the CDCLA. If it is desirable, this liability should apply equally to mothers and fathers. If it is not, there is a strong case for extending the maternal exemption to fathers as well. Changes in society since the CDCLA came into force mean that the problems associated with a child bringing a claim against her parent identified by the Law Commission in relation to maternal liability, such as taking funds away from those caring for the child, disturbing the parental bond, and the potential for use in matrimonial disputes, now apply equally to paternal liability. Therefore, it is likely that such liability would do more harm than good. This is not to say that the individual who does not disclose their HIV status to a sexual partner should not face any form of liability, only that liability to the child is not appropriate. Either parent could still face criminal and civil liability to each other in respect of their non-disclosure.

An alternative solution would be to remove the maternal exemption; however, the significant symbolic value of the exemption of maternal liability in reinforcing the principle that there is no legal obligation for women to prioritise the welfare of their future children would then be lost. It is possible that extending the exemption to include fathers would have a similar value to men. While there are historical and current social reasons for making a clear statement that women are not to be considered primarily as vessels for future children, this does not require the law to place men under an obligation to prioritise the welfare of their future children in a way that women are not. Indeed, the case against maternal liability would be strengthened by an equal statement applying to men as this would remove any objection to the maternal exemption based on unjustified unequal treatment. Therefore, it would appear that the most appropriate solution is for the exemption to be extended to fathers with an exception for intentional torts committed against the mother during pregnancy.

106 Brazier (n 9) 266.
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