

Neutral Citation Number: [2026] EWHC 2935 (KB)

Case No: KB-2024-001178

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13/11/2026

Before:

MR JUSTICE SWIFT

- -

Between

(1) ANN-MARIE ASHTON
(on behalf and for the estate of LUKE ASHTON, deceased)

(2) OLLIE LUKE ASHTON
(a minor acting by his mother and litigation friend, the First Claimant)

(3) INDIA ROSE PANCZEL **Claimants**

- and -

TSE MALTA LP **Defendant**

- -
- -

Jeremy Hyam KC, Jesse Nicholls and Rebekah Lee (instructed by **Leigh Day**) for the **Claimants**
Jonathan Hough KC, James Potts and Viktoria Winzer (instructed by **Keystone Law**) for the **Defendant**

Hearing dates: 4 – 5, 8 – 12, and 15 – 19 June 2026

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Approved Judgment

This judgment was handed down remotely at 2pm on 13 November 2026 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

MR JUSTICE SWIFT

A. Introduction

1. This claim arises from a tragic event. The First Claimant is the widow of Luke Ashton. Mr Ashton died by suicide on 22 April 2021. He was 40 years old.

2. Mr Ashton had a long history of gambling. His wife initially believed he was only an occasional gambler, betting on the outcome of football matches and other sporting events. In 2019 she realised her husband was a persistent gambler when it became apparent, he had run up a debt of £18,000, mainly as a result of online betting on horse races. However, Mrs Ashton believed her husband then stopped gambling and that by early 2020 his gambling debt had been cleared.

3. The evidence at trial painted a different picture. Mr Ashton had gambled online since 2009, he had online accounts with a number of gambling companies and used each account to a greater or lesser extent from time to time. The amounts he deposited in these accounts and used for betting varied from year to year. In 2010 he deposited almost £4,000; in each of 2011 and 2013 he deposited just over £1,000; and in 2012 he deposited almost £2,000. In 2014 and 2015 Mr Ashton spent little on his online accounts. From 2016 he deposited and gambled substantial amounts: in 2016, £2,600; in 2017, £2,800; in 2018, £6,000; in 2019, £15,000; in 2020, £4,600; and in the first 4 months of 2021, £10,600. Over the years Mr Ashton lost substantial amounts on these accounts: in 2016, some £1,000; in 2017, £1,200; in 2018, £2,500; in 2019, £11,100; in 2020, £2,600; and in the first 4 months of 2021, £7,500. These sums were significant for Mr Ashton – in the year ending April 2021 he and his wife's gross earnings came to a little under £57,000.

4. Mr Ashton went missing on 21 April 2021 and was found dead the next day. He had left messages for his wife and children. In one of the messages to his wife he said that his "... mental health [was] all over the place", referred to having "... demons in [his head]" and said "... gambling was just the straw that broke the camel's back".

5. The Claimants' claim against the Defendant, as set out in the Amended Particulars of Claim, is a claim in negligence brought under the provisions of the Law Reform (Miscellaneous Provisions) Act 1934 and the Fatal Accidents Act 1976. One premise of the claim is that Mr Ashton suffered from gambling disorder. Gambling disorder is a psychiatric disorder recognised in the Diagnostic and Statistical Manual of Mental Disorders (commonly referred to as "DSM-5"), published by the American Psychiatric Association. The Claimants contend that the Defendant's negligence exacerbated that disorder such that Mr Ashton came to suffer from a severe form of gambling disorder. This caused Mr Ashton distress, and that distress was central to his decision to take his own life. The particular focus of the claim is Mr Ashton's gambling activities in two periods: June to July 2019; and the first 4 months of 2021.

6. The Claimants' pleaded case is that the Defendant's negligence comprised its failure to prevent "known harm caused by gambling". The obligation to prevent that harm arose having regard to: the Defendant's knowledge that gambling can cause psychiatric harm and the particular risks of harm arising from exchange betting; the contractual

arrangements between the Defendant and Mr Ashton; the data available to the Defendant as a result of Mr Ashton's betting activity; and licencing and other conditions imposed on the Defendant under the Gambling Act 2005 ("the 2005 Act") and by the Gambling Commission.

7. The way in which the duty of care was framed was refined in the course of the hearing. This is not mentioned by way of criticism. Rather, such refinement is inevitable in a case like this one which revisits a difficult issue previously referred to as being "at the frontiers of negligence". In opening, Mr Hyam KC for the Claimants put the matter as there being a duty to take preventative steps to prevent the exacerbation of a psychiatric injury, namely Mr Ashton's gambling disorder. In this way he sought to draw a parallel between a duty of care owed in this case and the employer's duty of care in cases of psychiatric illness or injury as explained by the Court of Appeal in *Hatton v Sutherland* [2002] ICR 613. In the closing submissions the Claimants' final position on the duty was materially different. It was described as a duty to prevent a risk to Mr Ashton's health that arose when the Defendant was or ought to have been on notice that Mr Ashton may be at risk from suffering from gambling disorder. On the facts it was contended that the Defendant was or ought to have been on notice because of Mr Ashton's gambling activity in February and March 2021. The submission was that when the duty of care arose, the standard of care required was that the Defendant take the steps required by the Gambling Commission's social responsibility code. On the facts of this case it was said that required the Defendant in the first instance, to contact Mr Ashton by phone in order to understand and help him understand the reasons for his gambling conduct.

8. The evidence at trial has covered the following matters: the general circumstances of the First Claimant and Mr Ashton; details of the frequency and extent of Mr Ashton's gambling, with a focus on what he did in mid-2019 and in the early part of 2021; and evidence as to the nature and conduct of the Betfair online gambling business and its regulation by the Gambling Commission. Betfair is a trading brand/name used by the Defendant. Although this evidence was extensive, particularly the evidence of Mr Ashton's gambling, day by day, there was little in terms of factual dispute. Rather, the differences between the parties largely concerned evaluation and analysis of the evidence of fact. The parties have also led expert evidence: expert medical evidence on whether in the period April 2018 to April 2021 Mr Ashton suffered from a gambling disorder as defined in DSM-5; and expert evidence on the United Kingdom gambling regulation regime concerning whether the Defendant's business was operated in accordance with the Gambling Commission's licence conditions and social responsibility code of practice, and guidance issued by the Gambling Commission.

B. Facts

(1) Exchange betting

9. This claim concerns Mr Ashton's betting on the Betfair exchange. In each of 2019, 2020 and 2021 Mr Ashton gambled mainly if not entirely on the Betfair exchange platform. The exchange betting platform is an online platform and is one of a number of betting gambling products offered under the Betfair brand. Exchange betting is different from traditional "sports book", bookmaker betting. A betting exchange is a market place that matches customers who want to make bets and take bets from each other. The gambling company that provides the exchange profits by taking commission paid by winning customers. The rate of commission is typically between 2% and 8%

of the amount won. Richard Clarke, a Managing Director employed by Betfair Limited provided the following evidence that was not disputed:

> "11. An exchange, such as the Betfair Exchange, is different from a traditional bookmaker. In a more traditional "sportsbook" set up (such as the one that say William Hill, Sky Bet or Paddy Power have, and which Betfair offers as a separate sportsbook product) the operator offers its customers the opportunity to bet, for instance on the outcome of a football match. If the customer of a sportsbook agrees the odds offered, they will place the bet by staking the money with that operator. If the customer wins the bet, the operator will return the stake and pay the customer the winnings.
>
> 12. However, in an exchange, which requires a different licence from the Gambling Commission (a remote betting intermediary operating licence), the exchange operates as a marketplace (not unlike eBay for instance) in that when a customer offers to bet on the exchange, the operator matches that bet with one or more other customers who have offered bets on the opposite outcome. The operator acts as intermediary between the two customers, providing a platform so that they can contract with one another. The exchange does not place odds or take any risk in the betting contracts formed between customers and is not the counterparty.
>
> 13. In summary an exchange operates as follows. The customer first registers with the betting exchange website or mobile device app, and deposits funds which are held by the operator. The customer can then place bets on the exchange website/app against other customers at particular odds. Customers can either place a "back" bet (betting that something will happen) or a "lay" bet (betting that something will not happen). For example, Customer A offers odds on the exchange for a particular result not happening, and the exchange matches customer A up with one or more "backers" (Customer B), who bets at those odds that the result will happen.
>
> 14. When another customer accepts an offer (which could also be a fractional part of that offer), a contract is formed between the two customers, and the betting operator is authorised to deduct the appropriate sums bet from each customer's account and it places them into a holding account. When the outcome of the bet is known, the exchange operator pays out the winnings to the winner from the holding account. Thus, the loser's funds are transferred to the winning customer. The exchange deducts a commission from the winning party, usually in the region of 2-9% of the winnings, depending on the terms or conditions applicable to that account. If it has a competitive commission rate, high liquidity and a large customer

> base, an exchange will routinely offer more attractive odds in many markets in comparison to sportsbook offerings (including Betfair's own).
>
> 15. Unlike a traditional bookmaker, where almost all bets placed by a customer are likely to be instantly accepted, the vast majority of bets offered on the Betfair Exchange are never matched. I understand that internal data from the Betfair Exchange shows that, consistently about 99% of offered bets are never matched. That is because most odds being offered are not attractive enough for any customer to take before they lapse, are cancelled, voided or withdrawn. There may be lots of reasons for that, but often it will be because the customer has offered odds that are not attractive enough to the market, the circumstances have changed so the customer withdraws the offer before it has matched, or it is offered on an event ("a market") that has not attracted enough interest. The exchange is very fast moving and can accommodate bets offered in real-time as an event is taking place. Examples might be that a player may have been injured in a match or score a goal, or a horse has fallen at a fence, which will change the markets created in relation to that match or horse race. The markets and odds that might be available may change significantly, and instantly, in response to such events.
>
> 16. An exchange is therefore a way of betting which can be more time consuming and involving than traditional betting, and it tends to offer experienced and diligent users better returns. Because of that, exchanges, including the Betfair Exchange, tend to attract less "casual" customers (who might be more attracted to the simplicity and brand association of say, Sky Bet or Paddy Power) and more individuals who want to spend time and energy planning (although not necessarily more money) how and when they place offers to bet."

(*2*) *Statute and regulation*

10. Gambling taking place within Great Britain is governed by the provisions of the Gambling Act 2005. Section 20 of the 2005 Act established the Gambling Commission. Section 22 of the Act states the objectives of the Gambling Commission:

> "**22. Duty to promote the licensing objectives**
> In exercising its functions under this Act the Commission shall aim–
>
> (a) to pursue, and wherever appropriate to have regard to, the licensing objectives, and
>
> (b) to permit gambling, in so far as the Commission thinks it reasonably consistent with pursuit of the licensing objectives."

The licencing objectives are stated at section 1 of the Act, as follows:

> "**1. The licensing objectives**
> In this Act a reference to the licensing objectives is a reference to the objectives of–
>
> (a) preventing gambling from being a source of crime or disorder, being associated with crime or disorder or being used to support crime,
>
> (b) ensuring that gambling is conducted in a fair and open way, and
>
> (c) protecting children and other vulnerable persons from being harmed or exploited by gambling."

11. Sections 69 – 74 of the 2005 Act provide the Gambling Commission with the power to issue operating licences. An operating licence authorises a licence holder to provide one or more types of gambling facility. Under the Act it is an offence to provide facilities for gambling other than in accordance with the terms of an operating licence. When issuing a licence, the Gambling Commission has the power to specify the conditions that attach to it: see sections 75 – 77, 79 – 88 and 110 of the 2005 Act. Section 82(1) and (2) of the 2005 Act provide as follows:

> "**82. Compliance with code of practice**
>
> (1) An operating licence shall by virtue of this section be subject to the condition that the licensee ensures compliance with any relevant social responsibility provision of a code of practice issued under section 24.
>
> (2) In subsection (1) –
>
> (a) the reference to a licensee includes a reference to anyone employed or engaged by a licensee to perform an operational function within the meaning of section 80, and
>
> (b) the reference to a social responsibility provision of a code is a reference to a provision identified by a code as being included in pursuance of section 24(2)."

Section 24 of the 2005 Act requires the Gambling Commission to issue codes of practice "… about the manner in which facilities for gambling are provided …". Section 24(2) states:

> "(2) In particular, a code shall describe arrangements that should be made by a person providing facilities for gambling for the purposes of –

> (a) ensuring that gambling is conducted in a fair and open way,
>
> (b) protecting children and other vulnerable persons from being harmed or exploited by gambling, and
>
> (c) making assistance available to persons who are or may be affected by problems related to gambling."

12. Under the terms of its licence the Defendant was and is required to comply with licence conditions as from time to time published by the Gambling Commission. The conditions relevant to the circumstances of this case were the General Licence Conditions and Associated Code of Practice Provisions as in force during the relevant period. So far as concerns the Code of Practice, licence holders are required to comply with those provisions in it that are "social responsibility code provisions". In this case the Claimants draw attention to paragraph 3.4.1 of the social responsibility code which appears under the heading "customer interaction".

> "1. Licensees must interact with customers in a way that minimises the risk of customers experiencing harms associated with gambling. This must include:
>
> a. identifying customers who may be at risk of or experiencing harms associated with gambling.
>
> b. interacting with customers who may be at risk of or experiencing harms associated with gambling.
>
> c. understanding the impact of the interaction on the customer and the effectiveness of the Licensee's actions and approach.
>
> 2. Licensees must take into account the Commission's guidance on customer interaction."

13. The Claimants further draw attention to the "*Customer interaction – formal guidance for remote gambling operators*" published by the Gambling Commission in July 2019 and in force from October 2019 to September 2022 ("the Customer Interaction Guidance"/ "the Guidance").

14. Both by its nature and in its form the Customer Interaction Guidance is not strictly prescriptive. The primary matters arising from it that a licence holder must take into account may be summarised as follows. Licence holders should be aware of behaviours that could indicate harm relevant to online gambling, and take steps to identify customers who may be experiencing such harm. A range of indicators should be used for that purpose. The Guidance refers to matters including the timing and value of deposits, time spent gambling (in particular time spent gambling overnight), amounts lost, erratic use of gambling management tools, and patterns of gambling such as when players "chase losses". The Guidance encourages licence holders to attach realistic threshold trigger points to each indicator.

15. The Guidance also referred to "affordability", stating the following under the heading "*Affordability and customer's personal circumstances*".

> "2.8 Historically, gambling operators have not systematically considered customer affordability when developing their customer interaction policies. Many have used deposit or loss thresholds as a main or sole prompt for a customer interaction, but these have often been set at levels that were inappropriately high, in comparison to the average amount of money that the majority of people have available to spend on leisure activities. This has led to a number of examples of customers spending more than they could afford, and this not being identified sufficiently early, as seen in much of the Commission's compliance and enforcement case work since 2017.
>
> 2.9 Operators should aim to identify those experiencing or at risk of harm and intervene to try to reduce harm and at the earliest opportunity. Reliance on deposit or loss thresholds that are set too high will result in failing to detect some customers who may be experiencing significant harms associated with their gambling. It is therefore imperative that threshold levels are set appropriately.
>
> 2.10 Open source data exists which can help operators assess affordability for their GB customer base and improve their customer risk assessment for customer interactions. Thresholds should be realistic, based on average available income for your customers. This should include the Office of National Statistics publications on levels of household income.
>
> 2.11 In considering these thresholds, you should be aware of the difference between "disposable income" and "discretionary income" which refers to the amount left *after* living costs are taken into account, but it still does include many other unavoidable costs. Most people would consider it harmful if they were spending a significant amount of their discretionary income on gambling."

16. The Guidance further refers to making "… all reasonable efforts to make contact with …" customers, and to choosing "… the type of interaction based on the extent of the potential harm from automated responses to human contact … to try to get the best outcome".

(3) Betfair's gambling controls

17. The measures Betfair had in place by way of compliance with paragraph 3.4.1 of the Social Responsibility Code and the Customer Interaction Guidance were described in the evidence of Noel O'Keeffe, Susan Lawson and Daphne Tsatsoulis. This part of the evidence was not the subject of any relevant dispute. At all relevant times between 2018 and 2021 the Defendant had controls in place that were applied to all those

gambling on the exchange platform, including Mr Ashton. While the specific details of those measures changed over the period, at all times there were both reactive and predictive controls.

18. The reactive controls in place until February 2021 included the following: (a) daily and weekly deposit reports; (b) daily and weekly loss reports; (c) exchange activity reports that compared a customer's weekly loss to losses he had suffered in the previous 52 weeks; (d) reports based on times spent on the website generally each day and time spent on the website between 12am and 8am; (e) a report of occasions when a gambler had decided to withdraw money from his betting account but then cancelled that decision (a report that became redundant from May 2020 on the introduction of a prohibition on such cancellations). Each report applied set criteria to all those who gambled on the exchange. The criteria for deposit reports and the loss reports were set with the intention of identifying and flagging gamblers when bets or deposits exceeded a specified level and were out of the ordinary for that gambler. The time-related reports identified and flagged gamblers taking account of time spent on the website in the relevant period, and some or all of the number of bets cast, amounts deposited, amounts staked, and amounts lost.

19. When a report flagged a gambler, the action taken depended on how far the gambler's actions exceeded the criteria set for the report in question. The most common reaction was referred to as an "Automated SGI" (SGI standing for "safer gambling interaction"), in the form of an email or pop-up message on the gambler's online account. Examples of these messages and emails were in evidence. They were standardised communications that referred the gambler to one or more of the self-help tools available to all through the Betfair website, and provided a link to access one or more of those tools. Situations considered more significant would be reviewed by the Defendant's Safer Gambling Team and would prompt contact either by email, pop-up message or phone call. Cases considered the most significant would lead to a "Human Contact SGI" which would be a phone call, an online chat or an email message that required a response.

20. With effect from 1 February 2021 a new set of reactive controls referred to as the "Reactive Model", was put in place. The model took account of 6 different types of player behaviour of the type previously addressed by the daily or weekly reports, including levels of deposits and losses, and time spent on site. Each behaviour was scored against a metric. The scores were then aggregated, both daily and weekly, and a gambler's activity was then categorised as either low, medium or high risk or, in the case of low scoring gamblers, below the low risk band. Categorisation as high risk led to a Human Contact SGI; medium risk prompted review by the Safer Gambling Team; low risk resulted in an Automated SGI.

21. The Defendant's predictive measures used on the Betfair site were known as the Customer Activity Awareness Programme ("the CAAP"). Over the period 2017 to 2021 different iterations of the CAAP were applied. Each version aimed, by reference to gambling activity on an account, periodically, to predict whether the gambler fell into a class that would likely self-exclude within 14 days. Self-exclusion was (and remains) one of the self-help tools available on the Betfair website, referred to as "safer gambling tools". These tools are available to all gamblers using the Betfair exchange website. The thinking is that gamblers can use these tools to understand the extent of

their gambling and to decide on and apply sensible limits to that gambling. If a gambler decides to self-exclude, his account will be closed for a minimum of 6 months. The gambler can choose to self-exclude for a longer period, up to 5 years, or permanently. For the period of self-exclusion the gambling account remains closed and cannot be reopened. A decision to self-exclude is not synonymous with problem gambling, let alone any form of gambling disorder. For example, a person may decide to self-exclude because he wishes to spend his money on other activities. However, in some instances self-exclusion is a response to problem gambling. The CAAP adopted the likelihood of a decision to self-exclude as a proxy for problem gambling. The evidence was that self-exclusion was widely used by gambling companies as a proxy for problem gambling.

22. Each month every gambler's gambling activity was evaluated and assessed. The model worked by analysing account use data. The data points used have developed over time as different versions of the model have been developed, and are chosen having regard to public source information including, both the Problem Gambling Severity Index, a self-assessment questionnaire used in the Health Survey for England to measure the prevalence of persons experiencing problem gambling and, more recently, the Department of Housing Communities and Local Government Deprivation Index, that measures relative deprivation across England at a small local area level by reference to seven aspects of deprivation including income.

23. The CAAP had 3 risk categories: low, medium and high risk, referred to as stages 1, 2 and 3, respectively. If a gambler is assessed to fall within one or other of these categories an Automated SGI was sent. Different messages were sent depending on whether the player was in stage 1, stage 2 or stage 3, and depending on whether the player had previously appeared in that stage when previously assessed. The messages would, one way or another, provide information about the self-help safer gambling tools available on the Betfair website. The third version of the CAAP which began operating in September 2020 considered information on a daily, weekly, monthly and three-monthly basis. Human contact SGIs were also added for gamblers assessed as medium risk or higher over a monthly term. Gamblers assessed as high risk would also be subject to deposit limits or loss limits.

(4) The Defendant's customer contract

24. Each account on the Betfair exchange, including Mr Ashton's account, was governed by contractual terms and conditions. Among other matters, the contract included provision on "Responsible Gambling". This referred to a range of help devices, referred to as "Player Protection Tools", that were available to those who gamble on the Betfair website. These tools allowed gamblers to set limits on the amount they could: deposit at any time or over a set period for example each day, week, month or year (deposit limits); or the amounts they could lose in any set period (loss limits); to limit the amount of time they could spend using the Betfair exchange website (session timers); to set breaks from gambling for shorter periods (time outs); or to remove access to their accounts for longer periods (self-exclusion). A budget calculator tool was also available to assist gamblers to work out how much they could afford to spend.

(5) Mr Ashton's gambling

25. Mr Ashton had a history of gambling that went back to 2009. The evidence and submissions focused on two periods: June to July 2019; and the early months of 2021,

in particular March and April 2021. Mr Ashton's gambling activity dropped significantly from 15 April 2021. From then until his death, he gambled only on three days for a total of a little under 2½ hours. The information about Mr Ashton's betting habits in this period was drawn from the Defendant's gambling records. The records left little room for dispute on most matters of fact. The differences explored in evidence, primarily with the expert witnesses, were ones of analysis and evaluation.

26. In each period Mr Ashton gambled heavily. In June to July 2019 he deposited some £6,200, losing approximately £5,000. Between January and April 2021 Mr Ashton deposited a little over £9,800, losing just under £7,500. In each period Mr Ashton bet frequently and with increasing losses. His average bet size also increased. His losses in these periods were much more significant than any he sustained in any other period.

27. The period of significant deposits, betting and losses in June and July 2019 came to an end when Mr Ashton revealed his behaviour to his wife after she had discovered he debts of £18,000. Thereafter, for the remainder of 2019 and during 2020 Mr Ashton significantly reduced his gambling.

28. Mr Ashton's gambling in March and April 2021 was subjected to particular scrutiny. In March 2021 he deposited just over £7,000 and lost just over £5,600. In the course of the month he applied different deposit limits to his account. At the beginning of the month the deposit limit in place was £10.00 per month. On 5 March 2021 Mr Ashton increased this to £5,000 per month. On 10 March 2021 he changed the deposit limit again, reducing it to £10.00 per month. This remained in place until 20 March 2021. Mr Ashton then removed the deposit limit and no deposit limit applied until 30 March 2021. Mr Ashton then applied a limit of £10.00 per day that remained in place until 11 April 2021 when he changed the limit back to £10.00 per week.

29. In the period 20 March to 30 March 2021 Mr Ashton placed bets every day. On average he placed 64 bets each day. On 20 March 2021, having removed the £10.00 per month deposit limit, Mr Ashton deposited £295 into his account. On 23 March 2021 he deposited a further £600 and on 24 March he deposited £1,000. Mr Ashton's bank records which were disclosed in these proceedings, suggested that this latter deposit was made using money he had borrowed from a commercial lender. On 26 March 2021 Mr Ashton made two further deposits: £30 and £700. On 29 March 2021 he deposited £510 into his Betfair account.

30. Each day Mr Ashton spent significant time on the Betfair exchange website. Notwithstanding there was some disagreement about when times between bets should be taken into account, it was common ground that Mr Ashton spent at least 4 hours a day on the website. Overall, his activity on the website often started early in the day, and often continued late into the evening.

31. During March 2021 Mr Ashton received four Automated SGI messages: one on 6 March 2021 triggered by the amount deposited; and three others on 11 March 2021, 25 March 2021 and 27 March 2021 each triggered by the time he had spent on the Betfair website.

(6) Gambling disorder

32. Gambling disorder is one of the mental disorders classified in DSM-5. In the previous edition of the DSM the condition was referred to as "pathological gambling". Pathological gambling had been considered to be an impulse control disorder. In DSM-5, gambling disorder is categorised as an addictive disorder. Gambling disorder is a long term, relapsing and remitting condition. Treatment for it usually involves cognitive and behavioural therapy. On occasions, treatment includes medication. The prevalence of gambling disorder is low. The DSM states that the rate, by reference to the general population, is between 0.2 and 0.3%. In evidence it was accepted that this meant that of those that gamble, less than 1% are affected.

33. The DSM is a guide to the diagnosis of mental disorders. For each disorder criteria are listed. The criteria for gambling disorder are as follows:

> "A. Persistent and recurrent problematic gambling behaviour leading to clinically significantly impairment or distress, as indicated by the individual exhibiting 4 (or more) of the following in a 12-month period:
>
> 1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
>
> 2. Is restless or irritable when attempting to cut down or stop gambling.
>
> 3. Has made repeated unsuccessful efforts to control, cut back or stop gambling.
>
> 4. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next adventure, thinking of ways to get money with which to gamble).
>
> 5. Often gambles when feeling distressed (e.g. helpless, guilty, anxious, depressed).
>
> 6. After losing money gambling, often returns on another day to get even ("chasing" ones losses).
>
> 7. Lies to conceal the extent of involvement with gambling.
>
> 8. Has jeopardised or lost a significant relationship, job, or educational, or career opportunity because of gambling.
>
> 9. Relies on others to provide money to relieve desperate financial situations caused by gambling.
>
> B. The gambling behaviour is not better explained by a manic episode."

The DSM subdivides gambling disorder into three classes: mild, moderate and severe.

> "Severity is based on the number of criteria endorsed. Individuals with mild gambling disorder may exhibit only 4 – 5 of the criteria, with the most frequently endorsed criteria usually related to preoccupation with gambling and "chasing losses". Individuals with moderately severe gambling disorder exhibit more of the criteria (i.e., 6 – 7). Individuals with the most severe form will exhibit all or most of the 9 criteria (i.e., 8 – 9). Jeopardising relationships or career opportunities due to gambling and relying on others to provide money for gambling losses are typically the least often endorsed criteria and most often occur among those with more severe gambling disorder. Furthermore, individuals presenting for treatment of gambling disorder typically have moderate to severe forms of the disorder."

34. The DSM states the essential features of gambling disorder to be persistent gambling behaviour that disrupts personal or family life or work. Chasing of losses is characteristic of the disorder if it is frequent and long term. Those suffering from the disorder may lie or engage in deception both to hide the extent of their gambling and to obtain money to gamble. Generally, gambling disorder develops over a period of years. Most who suffer from the condition display a pattern of gambling that increases in frequency of gambling and in the sums being gambled. Milder forms of the disorder can develop into severe forms. It can be persistent and episodic and can lapse into remission.

35. The general part of the DSM emphasises the importance of holistic appraisal and clinical judgment to the application of any of the sets of criteria within the manual. Under the heading "*Approach to Clinical Case Formulation*" the following is stated:

> "The case formulation for any given patient must involve a careful clinical history and concise summary of the social, psychological, and biological factors that may have contributed to developing a given mental disorder. Hence, it is not sufficient to simply check off the symptoms in the diagnostic criteria to make a mental disorder diagnosis. Although a systematic check for the presence of these criteria as they apply to each patient will assure a more reliable assessment, the relative severity and valence of individual criteria and their contribution to a diagnosis require clinical judgment. The symptoms in our diagnostic criteria are part of the relatively limited repertoire of human emotional responses to internal and external stresses that are generally maintained in a homeostatic balance without a disruption in normal functioning. It requires clinical training to recognise when the combination of predisposing, precipitating, perpetuating, and protective factors has resulted in a psychopathological condition in which physical signs and symptoms exceed normal ranges. The ultimate goal of a clinical

> case formulation is to use the available contextual and diagnostic information in developing a comprehensive treatment plan that is informed by the individual's cultural and social context."

C. Decision

(1) Duty of care

36. The formulation of the applicable duty of care is the key issue in this case. Both parties' submissions on the duty of care started from the judgment of Briggs J in *Calvert v William Hill Credit Ltd* [2008] EWHC 454 (Ch). That case arose from the claimant's use of a phone betting service. The claimant sued to recover gambling losses he had incurred, first after he had requested his betting account be closed, and then after the defendant had failed to act on his later request to self-exclude (a request that he be excluded from phone betting for six months). The claim was put both as a claim for damages for pure economic loss, and as a claim for damages for personal injury on the basis that defendant's conduct had caused or aggravated the claimant's condition as a pathological gambler. The evidence before the court was that at the time the claimant made his requests he was a pathological gambler by reference to the criteria then stated in DSM-IV. DSM-5, which replaced DSM-IV, refers to a scale of "gambling disorder" in place of the previous labels of "problem gambler" and "pathological gambler". In broad terms, the assessment of the claimant in *Calvert* was the equivalent of an assessment, applying DSM-5, that he was on the border line between mild and moderate gambling disorder.

37. Notwithstanding that the case came to be put as a personal injury claim as well as a claim for compensation for economic loss, the parties' submissions and Brigg's J reasoning focused on the latter claim. So far as concerns the economic loss claim, the submission on duty of care was put in two ways, one broad the other narrower. The broad submission was:

> "153 ... that the common law should now recognise a duty of care on the part of a bookmaker to any customer appearing to be a problem gambler, first to take reasonable steps to offer assistance, including but not limited to a self-exclusion arrangement, and second to avoid unconsciously (by carelessness) exploiting the customer's vulnerability by permitting that customer to continue gambling."

38. Briggs J considered the existence of that duty of care. The factual premise for the broader duty was that when the claimant had first asked that his account be closed, explaining that it was "just too easy to gamble" and that he did not want the account to be reopened in any circumstances, the defendant ought to have treated that as a request by the claimant to be excluded from phone betting. Under a policy the defendant had adopted, self-exclusion went beyond mere closure of an account. If a customer closed his account he could if he chose, reopen the account or open another account the next day. If an account was subject to self-exclusion, it could not be reopened, in the first instance for 6 months, and no new account could be opened during that period. Briggs J considered the existence of that wider duty of care principally by reference to whether the defendant had voluntarily assumed the risk that a customer who appeared to be a

problem gambler would suffer economic loss. The contention for Mr Calvert was that the defendant had assumed that risk by putting in place the procedure allowing customers to self-exclude.

39. Briggs J's conclusion was that the duty posited in the claimant's broad submission did not exist. He did not consider problem gamblers as a:

> "… class that … uniformly suffer from such an impairment in their ability to control their gambling that it would be proper for the law to treat them without more, as being so vulnerable as to require special treatment, even in the absence of a request for it." (at paragraph 169)

He declined to limit the class to pathological gamblers because:

> "… it seems to me wholly unrealistic to suppose that in the ordinary course of its business a bookmaker can be expected to identify that sub-class by what amounts to a process of medical diagnosis". (at paragraph 170)

He was prepared to accept only:

> "… that the broad duty of care … may arise in relation to a customer whose behaviour has become so extreme as to demonstrate to a bookmaker that his gambling is wholly outside his control …". (at paragraph 170)

But did not consider that was the position on the facts before him.

40. Briggs J's reasoning was also informed by the notion of personal autonomy. At the beginning of his judgment he referred to the well-known passage in the speech of Lord Hoffmann in *Reeves v Commissioner of Police* [2000] 1 AC 360 at page 368 C – D.

> "… there is a difference between protecting people against harm caused to them by third parties and protecting them against harm which they inflict upon themselves. It reflects the individualist philosophy of the common law. People of full age and sound understanding must look after themselves and take responsibility for their actions. This philosophy expresses itself in the fact that duties to safeguard from harm deliberately caused by others are unusual and a duty to protect a person of full understanding from causing harm to himself is very rare indeed …."

Briggs J then continued:

> "2. ... Lord Hoffmann was speaking about harm in the form of personal injury or death. Although the unrestrained continuation of gambling, whether profitable or loss-making, may cause or aggravate what is now a recognised psychiatric disorder, the harm for which compensation is mainly sought in the present case, namely the financial ruin caused by gambling losses, represents economic loss. It follows that the recognition of a common law duty to protect a problem gambler from self-inflicted gambling losses involves a journey to the outermost reaches of the tort of negligence, to the realm of the truly exceptional."

41. Drawing these two themes together, the combination of the weight attaching to personal autonomy and to the practical difficulty facing any bookmaker attempting to identify problem gamblers was sufficient to limit the scope of any duty of care to an exceptional class of case where a claimant's gambling behaviour was "so extreme as to demonstrate a total lack of control". This was consistent with Briggs J's analysis of other case law including *Jebson v Ministry of Defence* [2000] 1 WLR 2055 and *Barrett v Ministry of Defence* [1995] 1 WLR 1217. As to the circumstances of these cases Briggs J observed:

> "151. These and other cases show that exceptional circumstances may give rise to a common law duty of care to prevent or to mitigate the consequences or aggravation of self-inflicted harm. Such circumstances may include the assumption of control over a person while vulnerable to the consequences of self-inflicted harm, or the assumption of some responsibility for the care of, or the provision of assistance to, such a person. In every such case the three stage test will be an important part of the analysis whether the circumstances are sufficiently exceptional."

42. Although the case based on the broad duty of care failed, Briggs J accepted that a more narrowly-framed duty did exist. This focused on the occasion when the claimant had requested self-exclusion but the self-exclusion had not been put in place. On this point the judge concluded:

> "175. I turn therefore to [the] narrower submissions, based upon [the] assurance to the claimant on 5th June 2006. In this context it seems to me ... the claimant presented himself as a problem gambler in need of help, asked for specific help, and was assured that he would be given it.
>
> 176. In my judgment those facts disclose a sufficient voluntary assumption of responsibility by William Hill to exclude the claimant from telephone gambling with the company

> for six months to give rise to a duty to take care to implement that exclusion, subject to the application of the three stage test, and the cross-check of incrementalism. In short, faced with a request for help from a person of some (albeit uncertain) vulnerability, William Hill chose to undertake to do that which was requested, without any disclaimer of legal responsibility.
>
> ...
>
> 178. It may be asked why, if no voluntary assumption of responsibility to problem gamblers generally was incurred by William Hill by its adoption and promulgation of its Social Responsibility Policy and Procedures, should there be identified a voluntary assumption of responsibility merely because a problem gambler requests that the procedure be applied to him. In my judgment the request and the undertaking in response make all the difference. First, it brings the parties into a degree of relationship akin to that of contract, save only for the absence of consideration. Secondly, it deprives the objection that the provision of assistance may infringe the gambler's autonomy of any force, since he has himself specifically requested it. As I have already suggested, the very essence of self-exclusion is that a problem gambler, recognising in a moment of clarity that he is likely to succumb to his addiction in the future, seeks his bookmaker's assistance in helping him to control what he fears will be otherwise uncontrollable when temptation returns. He is, in effect, putting the bookmaker on notice of his fear that, at precisely the time when he wishes exclusion to be imposed upon him, he will himself be unable to control his gambling. Absent that fear, there would be no point in self-exclusion at all.
>
> 179. The assumption of responsibility test being satisfied on that narrower basis, I turn therefore to the three stage test. Again, it seems to me that both financial and psychiatric harm from a failure of the self-exclusion process is sufficiently foreseeable. ...
>
> 180. Furthermore, there is no risk of indeterminate liability to an indeterminate class. In the context of a specific request for self-exclusion by a particular problem gambler, no question of class arises. ... As to fairness, I can see no particular reason why it should be regarded as unfair that a bookmaker who has undertaken, albeit without consideration, to exclude a problem gambler customer at his request, without making any disclaimer of liability, should incur a duty of care. ..."

43. Briggs J gave permission to appeal against his conclusion on the broad duty of care. Yet when the case did go to the Court of Appeal ([2009] Ch 330) it went only in respect of the judge's conclusion on causation on the part of the claim based on the narrower

duty of care. No appeal was pursued against the judge's conclusion on the non-existence of the claimed wider duty.

44. Mr Hough KC for the Defendant submitted that the duty of care contended for in this case was materially the same as the broad duty contended for in *Calvert* and rejected by Briggs J. Mr Hyam's submission was that the duty contended for was more narrow and, in any event, this claim was not a claim for damages for pure economic loss but rather a claim for damages for personal injury. That claim he submitted ought to be considered in accordance with the approach set out by the Court of Appeal in *Hatton v Sutherland*.

45. In terms of their general formulation, the broad duty rejected in *Calvert* and the duty of care the Claimants contend for in this case are materially the same. For what it is worth, in *Calvert* the broad duty was a duty to offer assistance "to any customer appearing to be a problem gambler". The closing submissions for the Claimants in this case were as follows. First, the written submission:

> "The duty of care contended for arises where a gambling operator has actual or constructive knowledge that a customer gambling on its platform (a gambler) exhibits clear signs or indicators that the gambler is, or may be, suffering impending harm to his health by reason of his gambling.
>
> Such clear signs or indicators, based on the [Gambling Commission guidance] of impending harm to health (as opposed to any other kind of harm) are likely to be found where there is an accumulation of indicators … which are not just indicative of gambling problems *per se* but are indicative of a person who may be suffering from a health disorder related to his gambling."

Then, this was the oral submission:

> "… the duty is to identify those at risk of harm to health and take preventative action, and the content of the duty is to set reasonable thresholds for identifying those at risk of harm to health and take that action."

The relevant harm to health being psychiatric harm in the form of gambling disorder.

46. I do not consider there is much to be gained from close comparison of the formulation of the duty in *Calvert* and the way in which the Claimants put their case here. The focus should be on substance rather than form. It is also important to note that while *Calvert* considered matters on the basis that the claim was for damages for pure economic loss, the claim here is for damages for psychiatric injury. The duty of care asserted in this case is novel, not because it is a duty in respect of psychiatric injury rather because of the context in which the duty is claimed to exist, that between a gambling company and one of its customers.

47. The general approach required when considering the existence and extent of a duty of care is set out in *Robinson v West Yorkshire Chief Constable* [2018] AC 736. There is

no single general principle that applies to every situation to determine whether and what duty of care exists. The proper approach rests on consideration of precedent and development of the law incrementally identifying the legally significant features of the situation considered in any earlier case: see per Lord Reed at paragraphs 21, 26 and 27. At paragraph 27 Lord Reed also stated:

> "... The courts also have to exercise judgement when deciding whether a duty of care should be recognised in a novel type of case. It is the exercise of judgement in those circumstances that involves consideration of what is "fair, just and reasonable". As Lord Millett observed in *McFarlane v Tayside Health Board* [2000] 2 AC 59 , 108, the court is concerned to maintain the coherence of the law and the avoidance of inappropriate distinctions if injustice is to be avoided in other cases. But it is also "engaged in a search for justice, and this demands that the dispute be resolved in a way which is fair and reasonable and accords with ordinary notions of what is fit and proper"."

The observations of Lord Toulson in *Michael v Chief Constable of Wales Police* [2015] AC 1732 are also apposite in the circumstances of this case which, in substance, is a case about failures to act:

> "102. It is true that the categories of negligence are never closed ... and it would be open to the court to create a new exception to the general rule about omissions. The development of the law of negligence has been by an incremental process rather than giant steps. The established method of the court involves examining the decided cases to see how far the law has gone and where it has refrained from going. From that analysis it looks to see whether there is an argument by analogy for extending liability to a new situation, or whether an earlier limitation is no longer logically or socially justifiable. In doing so it pays regard to the need for overall coherence. Often there will be a mixture of policy considerations to take into account."

48. The particular characteristics of claims for damages for psychiatric injury were considered by the Court of Appeal in *Hatton.* In this case the Claimants rely on the reasoning in *Hatton* in support of the duty for which they contend. In *Hatton* the claims considered all arose from employment and in each it was contended that the employer had failed to take steps to prevent psychiatric injury. The court recognised differences between physical and mental disorder that bore upon the existence of any duty of care. *First*, that whether psychiatric illness exists may be unclear. The dividing line between a normal but unpleasant state of mind and a recognised psychiatric illness could be difficult to draw. On this point the court placed reliance on internationally received classifications including the DSM. Conditions so recognised and classified could be the subject of viable claims. *Second*, the court recognised that the causes of psychiatric illness could be complex and might be the consequence of interaction between a

claimant's personality, his day to day actions or other events whether at work or outside work. *Third*, the court accepted that an employer's awareness of his employee's state of mind would be more limited than awareness of the employee's physical health such that while an employer could reasonably be expected to take responsibility for addressing workplace risks to physical health and keep those to a minimum, fixing responsibility for psychological risks would be less straightforward because an employer was less able to control, for example, an employee's response to stress at work. At paragraph 22, Hale LJ (giving the judgment of the court) stated:

> "22. There are, therefore, no special control mechanisms applying to claims for psychiatric (or physical) injury or illness arising from the stress of doing the work which the employee is required to do. But these claims do require particular care in determination, because they give rise to some difficult issues of foreseeability and causation and, we would add, identifying a relevant breach of duty. As Simon Brown LJ pithily put it in *Garrett's* case, at paragraph 63:
>
> > "Many, alas, suffer breakdowns and depressive illnesses and a significant proportion could doubtless ascribe some at least of their problems to the strains and stresses of their work situation: be it simply overworking, the tensions of difficult relationships, career prospect worries, fears or feelings of discrimination or harassment, to take just some examples. *Unless, however, there was a real risk of breakdown which the claimant's employers ought reasonably to have foreseen and which they ought properly to have averted, there can be no liability* ." (Emphasis supplied.)"

The court's conclusions were summarised at paragraph 43 of Hale LJ's judgment. So far as material for the present purposes they were as follows:

> "43. From the above discussion, the following practical propositions emerge.
>
> (1) There are no special control mechanisms applying to claims for psychiatric (or physical) illness or injury arising from the stress of doing the work the employee is required to do (para 22). The ordinary principles of employer's liability apply (para 20).
>
> (2) The threshold question is whether this kind of harm to this particular employee was reasonably foreseeable (para 23): this has two components (a) an injury to health (as distinct from occupational stress) which (b) is attributable to stress at work (as distinct from other factors) (para 25).
>
> (3) Foreseeability depends upon what the employer knows (or ought reasonably to know) about the individual employee. Because of the nature of mental disorder, it is harder to foresee

> than physical injury, but may be easier to foresee in a known individual than in the population at large (para 23). An employer is usually entitled to assume that the employee can withstand the normal pressures of the job unless he knows of some particular problem or vulnerability (para 29).
>
> ...
>
> (5) Factors likely to be relevant in answering the threshold question include: (a) the nature and extent of the work done by the employee (para 26). Is the workload much more than is normal for the particular job? Is the work particularly intellectually or emotionally demanding for this employee? Are demands being made of this employee unreasonable when compared with the demands made of others in the same or comparable jobs? Or are there signs that others doing this job are suffering harmful levels of stress? Is there an abnormal level of sickness or absenteeism in the same job or the same department? (b) Signs from the employee of impending harm to health (paras 27 and 28). Has he a particular problem or vulnerability? Has he already suffered from illness attributable to stress at work? Have there recently been frequent or prolonged absences which are uncharacteristic of him? Is there reason to think that these are attributable to stress at work, for example because of complaints or warnings from him or others?
>
> (6) The employer is generally entitled to take what he is told by his employee at face value, unless he has good reason to think to the contrary. He does not generally have to make searching inquiries of the employee or seek permission to make further inquiries of his medical advisers (para 29).
>
> (7) To trigger a duty to take steps, the indications of impending harm to health arising from stress at work must be plain enough for any reasonable employer to realise that he should do something about it (para 31). ..."

49. A number of matters are relevant to the existence and scope of any duty of care in the present case. There is some parallel between the employment situations considered in *Hatton* and this case to the extent that both arise from contractual relationships that have been overlaid by statutory regulation such that one party is assumed to have a level a responsibility for safeguarding the wellbeing of the other. The duties of employers in this regard are well known, both those that arise from statute and other, largely similar, implied contractual obligations. The obligations of those such as the Defendant who are providers of gambling facilities arise under the 2005 Act. They must comply with the social responsibility requirements in the Gambling Commission's Code of Practice, including the requirement at paragraph 3.4.1 of the Code to deal with customers in ways that will reduce the risk that that they will "[experience] harm associated with gambling".

50. Yet equally plainly there are material differences. The nature of the relationship arising from each type of contract is very different. The key characteristics of an employment contract, the obligation to provide personal service and the mutual obligation to maintain the necessary relationship of trust and confidence, find no equivalent in contracts such as the contract in this case by which the Defendant agreed to make gambling services available to Mr Ashton. Mr Ashton was a consumer of those services. The services made available were provided through a website. Provision of those services through the website generated a gambling record, data held by the Defendant on when and how Mr Ashton gambled and the outcome of that gambling. But the Defendant's possession of that data and use of it through its responsible gambling controls to appraise how Mr Ashton gambled did not establish a relationship that was qualitatively equivalent to an employment relationship.

51. In the context of the relationship between a gambling company and its customers the principle of respect for personal autonomy, which was a significant feature of Briggs J's reasoning in *Calvert*, must carry particular weight in any analysis of the existence of a duty of care to prevent psychiatric injury. So far as concerns this principle, the circumstances of the present case are not the same as those considered by the Court of Appeal in *Hatton*. In employment situations the principle of autonomy is less relevant both because the employee's obligation to provide his services is the essence of the relationship (in the present context there is no corresponding obligation to gamble), and because the employer ordinarily exercises control over how and where and when the employee works. In these important respects the context for the present case is materially different.

52. A gambler chooses to gamble, and the risks associated with gambling are well-documented. These risks are not limited to the risk of psychiatric illness in the form of gambling disorder. They extend to risks of harm to wellbeing short of psychiatric illness, the risk of harm to personal relationships, and the obvious risk of financial loss. Nevertheless, gambling is a lawful and everyday activity. Notwithstanding that in DSM-5, gambling disorder is classified as an addictive disorder, gambling is not prohibited. Rather, the Gambling Act 2005 represented a sea change in law and public policy. The White Paper that heralded the 2005 Act stated that gambling should no longer be assumed to be objectionable or an activity that people should be encouraged not to pursue; the risk of problem gambling was to be addressed by public regulation. One of the Gambling Commission's duties under the 2005 Act is to permit gambling so far as consistent with the licencing objectives, i.e. that it is not a source of crime and disorder, is conducted fairly and openly, and in a way that avoids exploitation of or harm to children and vulnerable persons (see the 2005 Act at section 22, and section 1).

53. Those who choose to gamble may make decisions that others may reasonably regard as poor choices, whether by choosing to gamble at all or in the way in which or extent to which they gamble. However, respect for personal autonomy requires respect for the freedom to act unwisely. In this respect the present case is closer to the situations considered in *Barrett* (see per Beldam LJ at page 1224 D-F and page 1225 E-F) and *Jebson* (see per Potter LJ at paragraph 28) and in *Watson v British Board of Boxing Control* [2001] 2 WLR 1256 (per Lord Phillips MR at paragraph 87) than to those before the Court of Appeal in *Hatton.* In each of these cases the existence of a duty of care to take steps to prevent physical injury arose only from special circumstances.

54. The final consideration is what significance attaches, for present purposes, to the scheme of regulation under the 2005 Act. The striking feature of the Claimants' case on duty of care is that the duty claimed is a duty to look for signs of gambling disorder and to respond to those signs by taking steps equivalent to those required by the Gambling Commission's regulatory standards. In substance, therefore, the Claimants' case seeks to map the Gambling Commission's regulatory scheme and purpose onto the law of tort. That is striking not the least because it results in a duty of care that stretches much further and wider than any duty recognised by the Court of Appeal in *Hatton*, or in any other case. Three of the four cases considered by the Court of Appeal on that occasion failed because the court considered general matters such as absence or ill health had not provided sufficiently clear indications of psychiatric injury: see per Hale LJ at paragraphs 48,59, and 72.

55. Turning to the statutory and regulatory scheme, section 24(8) of the 2005 Act provides that failure to comply with the Gambling Commission's Code of Practice "*... shall not of itself make a person liable to ... civil proceedings*." As a matter of simple language that provision is not, *per se*, a determinative answer to claims such as the one in these proceedings. But it is significant, and it must inform what the content of any common law duty of care might be. The points made by Lord Rodger in his speech in *Barber v Somerset County Council* [2004] 1 WLR 1089 at §§30 and 34 – 35 are pertinent. In that case (which was an appeal against a conclusion reached by the Court of Appeal in *Hatton* on the facts of one of the claims before it), Lord Rodger considered the interrelationship between the terms and conditions in the employment contract in that case and the proper scope of a duty of care. He doubted the wisdom of any duty of care that derogated from the parties' respective contractual obligations. The point in this case is not that the duty of care contended for would reset or recalibrate regulatory standards, but that by adopting them the duty of care would tend to usurp the position and role of the statutory regulator, and for that reason is an inappropriate development of the common law. In other words, that proper regard to section 24(8) of the 2005 Act requires the conclusion that the common law duty of care ought not simply to follow regulatory standards set by the Gambling Commission.

56. Consideration of the content of the Code of Practice and the Gambling Commission's Guidance reinforces that conclusion. Three points emerge. The *first* is that the reach of regulation can be very wide, making it an inappropriate guide to the reach of tortious liability. The material part of the Code of Practice, paragraph 3.4.1 sets broad requirements. Licence holders such as the Defendant should identify customers who are or may be "experiencing harms associated with gambling", and "interact with them", and are required to understand the impact and effectiveness of the steps they take. This requirement covers ground extending far beyond any common law obligation presently recognised. Taking just one point, "harms associated with gambling" is clearly not intended to be limited to recognised psychiatric illness or injury.

57. The *second* point is that regulatory requirements will not be formulated in ways that make them apt to be predictable yardsticks for tortious liability. Licence holders "must take into account" the Gambling Commission's guidance. The Guidance is more open textured than narrowly prescriptive. For example, licence holders are told to know "types of markers and behaviours that could indicate harm relevant to online gambling", and know how to spot them. Licence holders are encouraged to use a range of indicators

both financial and non-financial, and are referred generally to the need to train staff and the need to encourage their customers to use gambling management tools. All this (and all further matters set out in the Guidance) are prudent regulatory provisions, but they do not provide reliable markers for the existence or content of a common law duty of care.

58. In his submissions, Mr Hyam sought to distinguish duty of care and standard of care, submitting that the Gambling Commission's regulatory standards went only to the latter, not the former. I do not consider that in a case such as this where the existence of a duty of care in novel circumstances is in issue, any such clear distinction ought to be drawn. Any decision on the existence of a duty of care in this case ought to be informed by consideration of the standard of care that would follow.

59. The *third* point is that the application and development of statutory regulatory standards is better left to the bodies entrusted with that task by statute. It is in the nature of regulation that regulatory standards develop in response to political and public opinion. The development of regulatory standards in response to those demands is a matter of policy within the remit of the Gambling Commission, a specialist public authority. It is better left there than assumed by the courts, not least because of the complexity of the situation. By way of example one part of the Claimants' case was whether Mr Ashton had been allowed to gamble to an extent that the defendant ought to have considered unaffordable for him. That, it was contended, comprised a breach of duty that affected Mr Ashton's mental health. The proper approach to ascertaining affordability in this scheme of regulation is a matter of difficulty both political and practical. The Gambling Commission's 2019 Guidance referred to affordability stating that thresholds for contact based on levels of deposits made or levels of losses suffered should be "set appropriately" and " based on average available income for your customers". The Guidance then stated, "most people would consider it harmful if they were spending a significant amount of their discretionary income on gambling" (Guidance at paragraph 2.11 – see above at paragraph 15). In principle that is a sensible statement, albeit in practice many people's spending habits will fluctuate so that while over the longer term the outgoings and income will coincide that may not be the case over shorter periods, and a person's spending priorities will also vary from time to time. Be that as it may, the sentiment that whether gambling is affordable should bear some correlation to discretionary income would amount to little without access to information about a gambler's financial circumstances. By what means and to what extent that should be achieved remains a work in progress. The 2019 guidance referred to Office of National Statistics publications on household income. But that information at best is generic and area based, and may not be of great assistance in a particular case. After the Guidance was issued, affordability was considered, first by a House of Lords Select Committee in July 2020, and then in a government White Paper published in April 2023. But there was no consistent approach to how affordability should be ascertained. The White Paper requested the Gambling Commission to consult on how checks on an individual's financial position might be undertaken. A pilot scheme was run from August 2024 and the results remain under consideration.

60. These points satisfy me that a duty of care that effectively adopts the Gambling Commission's regulatory standards into the law of tort ought not to be recognised. In this area, regulation rests on sensitive assessments of social policy. The regulatory standards that are in place lack hard edges and are instead framed in terms of outcomes.

Drawing these matters together, I do not accept the Claimants submission on the formulation of the duty of care. The reasoning of the Court of Appeal in *Hatton* warrants that some duty of care should exist but the duty should be constrained, recognising that the relationship between a gambling company and those who gamble is not the same as that between employer and employee, and is a relationship in which respect for autonomy must carry significant weight.

61. The duty of care that should exist should be no more than a duty to act to prevent gambling disorder in its severe form when that form of the disorder is foreseeable. This limitation of the potential for liability to the most serious form of gambling disorder affords proper weight to the principle of autonomy. Problem gambling and the possibility of gambling disorder is a well-known risk that arises when a person decides to gamble. DSM-5 states that most people who gamble will do so without experiencing problems, and that the prevalence of gambling disorder is low. Nevertheless, those who choose to gamble choose to expose themselves to that risk. Moreover, those who gamble and experience problem gambling even to the extent of gambling disorder in its mild or moderate forms should accept some responsibility to address those consequences.

62. The approach of the scheme of statutory regulation strikes a different balance. It places obligations on gambling companies that apply from the point when each customer first gambles. The regulatory scheme requires that from the outset, gambling companies encourage gamblers to gamble responsibly; it requires the companies to provide the safer gambling tools to encourage gamblers to be aware of their own circumstances; and it requires gambling companies to monitor how each gambler gambles and to discourage excessive gambling. But this is not a sensible guide to the scope of a tortious duty of care. Any attempt to reflect such regulatory requirements in the duty of care would both go against the grain of the 2005 Act (section 24(8)) and result in a radical extension of tortious liability for psychiatric injury and for circumstances falling short of psychiatric injury. The proper place for a tortious duty of care is situations beyond the limits of genuine and informed choice. The further advantage of this approach in this case is that it is consistent with the rationale of Briggs J in *Calvert*, see for example, his judgment in paragraph 151 (see above in this judgment at paragraph 41).

63. The requirement of foreseeability must also be applied realistically as it was in each of the cases considered by the Court of Appeal in *Hatton*. In *Hatton* Hale LJ put the matter in this way, emphasising the significance of the employer's knowledge.

> "23. To say that the employer has a duty of care to his employee does not tell us what he has to do (or refrain from doing) in any particular case. The issue in most if not all of these cases is whether the employer should have taken positive steps to safeguard the employee from harm: his sins are those of omission rather than commission. ... the threshold question is whether this kind of harm to this particular employee was reasonably foreseeable . The question is not whether psychiatric injury is foreseeable in a person of 'ordinary fortitude'. The employer's duty is owed to each individual employee, not to some as yet unidentified outsider: see *Paris v Stepney Borough Council* [1951] AC 367 . The employer knows who his

> employee is. It may be that he knows, as in *Paris*, or ought to know, of a particular vulnerability; but he may not. Because of the very nature of psychiatric disorder, as a sufficiently serious departure from normal or average psychological functioning to be labelled a disorder, it is bound to be harder to foresee than is physical injury . Shylock could not say of a mental disorder, 'If you prick us, do we not bleed?' But it may be easier to foresee in a known individual than it is in the population at large . The principle is the same as in other cases where there is a contractual duty of care, such as solicitors' negligence: ... ."

64. In cases such as this a defendant's state of knowledge should be critical. Cases will depend on their facts. In some, a gambling company's connection with the gambler may be no more than the gambler's use of its website. A company may know very little about that person beyond its record of his gambling transactions. I do not consider that possession of data collected as part of a record of a gambler's activity can be equated with foreseeability of psychiatric injury. As discussed below in the context of the expert medical evidence in this case, assessment of a gambling disorder depends on much more than simple consideration of data patterns. In other situations the relationship between the gambling company and the gambler may be different. By way of example, I was referred to the judgment in *Gibson v TSE Malta* (t/a Betfair) [2024] EWHC 2900 (Comm). The claimant in that case was a "VIP" customer whose account was managed by a specialist team in regular contact with him.

65. In all cases the approach to foreseeability, resting on knowledge, must be a testing standard and must afford full weight to the practical considerations highlighted in the judgment in *Calvert* both that gambling disorder is a broadly-framed condition apt to cover a range of circumstances, and that it is unrealistic to expect those who provide gambling facilities to undertake anything approaching psychiatric diagnosis. In practice, adopting Hale LJ's turn of phrase in *Hatton*, a risk of severe gambling disorder will be "plain enough" for any reasonable gambling company to realise that it should act and will therefore be sufficiently foreseeable, either when the company is on notice of a diagnosis of gambling disorder in any of its forms (mild, moderate or severe), or where adopting Briggs J's formulation in *Calvert,* the customer's behaviour "has become so extreme as to demonstrate … that his gambling is wholly outside his control".

66. The combined effect of these matters is a narrowly-framed duty of care where the claim is a claim for damages for psychiatric injury. It goes without saying that such claims for damages do not reflect the full extent of a gambling company's potential legal liability to those who gamble with it. One obvious example is the circumstances of the part of the claim in *Calvert* that succeeded where the defendant gambling company failed to comply with a request for self-exclusion. A similar case arising now might more suitably be framed as a contractual claim. The contracts between gambling companies and gamblers are now sophisticated documents incorporating some aspects of the measures that support so-called "safer gambling".

(2) Duty of care in the present case

67. On the facts of this case the first issue is whether the Defendant knew or ought to have known whether in mid-2019 or in the period January to April 2021, that Mr Ashton suffered from any form of gambling disorder.

68. During his life Mr Ashton was not diagnosed as suffering from gambling disorder. His medical history did not assist. Mr Ashton's medical records were part of the disclosure in this case and were considered by each of the expert medical witnesses Dr John Barker, instructed for the Claimants, and Dr Humphrey Needham-Bennett, instructed for the Defendant. There was no mention in those records of any gambling problem or any mental disorder, or of treatment for any mental disorder. In 2019 Mr Ashton was prescribed amitriptyline a drug that can be used for treatment of depression. However, when prescribed for Mr Ashton it was prescribed in a small dose and was used as a treatment for neuropathic pain.

69. The case for the Claimants was put on the basis that in 2019 and in 2021 he did suffer from gambling disorder and that his behaviour was such that the Defendant ought to have known that he suffered from gambling disorder. This case rested on Dr Barker's opinion formed post mortem and resting primarily on evaluation of any inferences drawn from the record of Mr Ashton's gambling with the Defendant. Dr Barker's report considered the DSM-5 criteria. His conclusion was that Mr Ashton suffered from a severe gambling disorder because he met all but one of the nine diagnostic criteria (the one not met was criterion 2 "is restless and irritable when trying to cut down or stop gambling"). Dr Barker stated the following at paragraph 35 of his opinion:

> "At the time of Mr Ashton's death in April 2021, my opinion is that his Gambling Disorder would have been at its most severe, with the presence of all eight of the symptoms I have described above. Throughout the Relevant Period my opinion is that he would also have met the threshold for a diagnosis of Gambling Disorder, but that this progressively worsened throughout that time as he sought, unsuccessfully, to control his addiction and to mitigate some of the psychosocial consequences of this. Treatment by a recognised NHS gambling service at any point during the Relevant Period would have been indicated and would have been intended to halt the steady accretion of symptoms, for example the clear chasing of losses in March 2021 referred to in paragraph 22 above, which I believe represents a clear and significant deterioration in his presentation."

The "relevant period" referred to was 18 April 2018 to 22 April 2021.

70. Dr Needham-Bennett's opinion was to the contrary. In his report he pointed out that a diagnosis of gambling disorder would normally be made only after a full clinical interview which considered a patient's whole medical and psychiatric history. Although in this case there was significant data about Mr Ashton's gambling there was no, or next to no, evidence about his attitudes or feelings, no evidence of why he gambled, what he got from gambling and whether he believed his gambling to be a problem. Similarly, while data might be able to show that a person gambled with

increasing frequency or with larger amounts of money it might say little about that person's motivation, for example whether he was chasing losses or gambling more to achieve excitement. In his report Dr Needham-Bennett said this:

> "174. I must stress the difficulty of determining the presence of a gambling disorder based only on gambling patterns. Most psychiatric disorders (degenerative conditions aside) have no biological markers – there is no medical test for them, no X-ray and no lab analysis. This is especially true for 'gambling disorder' which relies mainly on subjective information provided by the patient.
>
> 175. It is for these reasons that I think that any diagnosis reached in Mr Ashton's case, must be made cautiously and heavily caveated by the limited information available."

71. Dr Needham-Bennett's conclusion on the application of the DSM diagnostic criteria was as follows (the criteria referred to are those above at paragraph 33):

> "**Diagnostic criteria**
> 220. Taking the nine criteria for gambling disorder, in my opinion, two are met, one is possible, one is not met and there is insufficient evidence to score the remaining five.
>
> 221. A score of four would be needed to meet the criteria for a mild gambling disorder.
>
> 222. In my opinion, whilst it is possible that he had a gambling disorder in the relevant period, there is insufficient clinical evidence to make a clinical diagnosis post-mortem.
>
> 223. If Mr Ashton were available to talk to a clinician, one would be saying, 'Well obviously, I need to interview him to make a diagnosis.'
>
> 224. I don't think any clinician should be confident in a diagnosis given the information is primarily about his betting patterns and there is a paucity of information directly addressing the largely subjective and patient defined criteria inherent in DSM-5.
>
> **Severity**
> 225. I don't think it is possible to comment on the dates of any potential disorder or their severity, beyond to note that there are two periods when Mr Ashton's gambling and losses was clearly greater than at other times, namely the summer of 2019 and the early part of 2021.
>
> 226. In saying this, I must emphasise that betting often and betting with higher amounts of money are not features of gambling disorder. I mention these periods simply because if he

> were to have a gambling disorder, it would be more likely to be apparent over these periods.
>
> **Symptoms suffered or displayed**
> 227. It is difficult to comment on what symptoms he might have been suffering from.
>
> 228. It is easier to comment on those he was displaying; it seems likely he displayed none.
>
> He did not report any to the GP. He did not disclose any to the pharmacist with a special interest in mental health matters, when booking on, at a new general practice just days before his suicide.
>
> He did not report symptoms to people close to him. Based on his wife's account, there were no symptoms suggestive of an underlying mental disorder or gambling disorder in the period prior to his death, let alone any 'red flags' indicative of a suicide risk."

Dr Needham-Bennett's conclusion was that criteria 7 and 8 were met in the relevant period, that it was possible that criterion 3 had been met, and that criterion 9 had not been met. He concluded that the information available was insufficient to reach any conclusion on the remaining criteria.

72. Both experts were cross-examined. Each answered all questions to the best of his knowledge and skill. I am grateful for their assistance. I prefer Dr Needham-Bennett's evidence on the application of the DSM diagnostic criteria and I accept his conclusion that there is insufficient evidence to show that Mr Ashton suffered from gambling disorder. If a conclusion on the matter is required, on the evidence available my conclusion is that Mr Ashton did not suffer from any form of gambling disorder within the DSM-5 criteria.

73. Dr Barker's conclusions on the application of four of the nine DSM-5 criteria (criteria 1, 3, 4 and 6) rested only on the gambling data. The matters relied on in his report were generally sparse: for criterion 1 he relied on gambling activity in February 2021 and principally what had happened on 10 February 2021; for criterion 3 he relied on two events, one from March 2019 the other from June 2020; for criterion 4 he relied on the pattern of gambling in March 2021; for criterion 6 he relied on what had happened on 5 March 2021. The cross-examination of Dr Barker considered the objective evidence in the gambling record in greater depth. This only reinforced the conclusion that his conclusion that the criteria applied drew only thin support from the objective data.

74. Further, Dr Barker reached his conclusions notwithstanding the absence of subjective information, and notwithstanding that the focus of each criterion stated in DSM-5 is largely if not entirely subjective.

75. Dr Barker's attempt to fill this gap by drawing inferences from data taken from the gambling record was not convincing, either in his report or in cross-examination. The evidence Dr Barker relied on in respect of each of criteria 5 and 7 – 9 was also thin.

There was evidence relevant to each, albeit that evidence led at trial to the effect that the loans Mr Ashton had accrued by 2019 were not paid off but rather continued to be serviced by him tended to suggest criterion 9 was not met. But I do not consider that evidence, taken in the round made good Dr Barker's conclusion that Mr Ashton suffered from a severe gambling disorder.

76. Overall, Dr Barker's reasoning was not convincing and did not overcome the significant difficulty that the Claimants' case faced on this point, namely the absence of information going to Mr Ashton's reasons and motivation and the emotional impact of gambling on him, all of which are matters that go to the heart of the diagnostic analysis.

77. The reasoning in Dr Needham-Bennett's report was much more cogent. His conclusions on the application of the DSM criteria was set out in a table at paragraph 219 of his report. That analysis speaks for itself. It is careful, considered and thorough. I accept it.

78. Since there is insufficient evidence to support a conclusion that Mr Ashton suffered from gambling disorder the Claimants' claim must fail. From this conclusion it must follow that there is no sufficient evidence to support any further conclusion that any time in the period from July 2019 to April 2021 the defendant knew or ought to have known that Mr Ashton suffered from gambling disorder. The duty of care on which the Claimants' case must stand or fall did not arise.

(3) Standard of care and other matters

79. Given my conclusion on the existence on the duty of care on the facts of this case any conclusions I might reach on standard of care will be academic. For that reason I will address this point only briefly.

80. The gambling industry experts, Professor David Forrest for the Claimants, and David Clifton for the Defendant provided evidence on the standard of care issue. The questions each was asked to address were as follows:

> "*Question 1*. Having regard to the Gambling Commission's Licence Conditions and Social Responsibility Codes of Practice ("LCCP"), contained within those editions of the LCCP that were in force during the period from 18 April 2018 to 22 April 2021 (the Relevant Period), relevant guidance issued by the Gambling Commission and any other relevant standards or guidance, what policies and procedures should have been adopted during the Relevant Period by the operator of an online betting exchange to manage risks of gambling-related harm?
>
> *Question 2*. During the Relevant Period, did the [Defendant's] above-mentioned policies and procedures as outlined in its evidence, and their implementation in respect of Mr Ashton by the [Defendant's] staff and automated systems, meet the standards of reasonable industry practice?

> *Question 3*. What would the records available to the [Defendant] during the Relevant Period have revealed to a responsible operator of an online betting exchange about the nature and extent of Mr Ashton's gambling?".

Thus the premise of all the evidence led was that the standard of care would mirror the social responsibility provisions in the Gambling Commission's Code of Practice, and also in the Guidance issued by the Commission, and that the relevant question was whether the system of reactive and predictive controls the Defendant had put in place had been sufficient to meet any/all of those regulatory standards.

81. It follows from my conclusion on the correct formulation of the duty of care that that premise is incorrect. The duty of care is an obligation to prevent foreseeable psychiatric injury in the form of severe gambling disorder. While foreseeability must always depend on the circumstances of a case, severe gambling disorder will likely be foreseeable only when a gambling company is either on notice of a diagnosis of gambling disorder in any of its forms, or where it was on notice that a gambler's gambling behaviour was so extreme as to demonstrate a total lack of control. The action required of a gambling company in such circumstances, the standard of care, would be to cease to provide gambling services to that gambler.

82. The regulatory requirements and the steps taken by the Defendant to meet those requirements do not provide the suitable standard of care because the general objective of the regulatory scheme is to identify and manage "gambling related harm", a category of circumstances that is much wider than even gambling disorder: i.e., it is a category including conditions that fall short of any recognised psychiatric injury, let alone gambling disorder in its severe form. For this reason it is unnecessary for me to address the industries experts' evidence in any detail.

83. The tenor of Professor Forrest's evidence was that the trigger points in the Defendant's reactive and predictive controls had been incorrectly set. Had they been set correctly Mr Ashton's gambling would have prompted a larger number of Automated SGI responses and ought to have resulted in better and more effective intervention, for example phone calls that could have led to a better understanding of what Mr Ashton was doing and what response was appropriate.

84. The circumstances of Mr Ashton's death did lead the Gambling Commission to consider regulatory compliance. The Gambling Commission reviewed events leading to Mr Ashton's death so far as they concerned gambling regulation. In November 2021 the Commission decided that no action was required. However following the inquest in Mr Ashton's death the Coroner issued a Prevention of Future Deaths ("PFD") report. In that report the Coroner stated his concern that the Defendant's player protection tools had been inadequate. The Gambling Commission responded to the PFD report stating that it intended to consider matters further in light of the Coroner's findings. It was obviously appropriate for the Gambling Commission to consider these tragic circumstances and to consider the social responsibility provisions in its Code of Practice. Nevertheless, as was apparent from the evidence of the industry experts the Gambling Commission's social responsibility provisions are not designed to be prescriptive in the sense of setting a model of rules to be followed by all gambling companies across all their range of gambling services. Rather, the regulatory standards

set out general principles recognising that the responses of gamblers to gambling are more likely to be personal than uniform, such that devising schemes to give effect to regulatory requirements directed to a general notion of gambling related harm can be a difficult and subtle task. That being so, and without in any way seeking to detract from the importance of those regulatory standards aimed as they are at the promotion of public safety, they are an inapt starting point for any tortious standard of care in a case such as this.

85. I need not therefore consider them further in this case. Nor, given the conclusions I have reached need I consider the further submissions that were made by the parties on causation and on contributory fault.

D. Disposal

86 The duty of care the Claimants contend for did not arise on the facts of this case. The Defendant was subject to a duty of care to act to prevent Mr Ashton suffering foreseeable psychiatric injury viz, gambling disorder in its severe form. The possibility of such injury would be foreseeable if the Defendant had known or ought to have realised that Mr Ashton suffered from either mild or moderate gambling disorder (following the approach set out in paragraph 81 above). However the Claimants fail on the foreseeability issue. There is no sufficient evidence to support the conclusion that Mr Ashton did suffer from gambling disorder and that being so, no possible basis on which the requirement for foreseeability could be met.

87. The Claimants' case therefore fails, and is dismissed.