



Neutral Citation Number: [2024] EWHC 753 (KB)

Case No: KB-2023-001368

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 15/04/2024

Before :

MR JUSTICE JULIAN KNOWLES

Between :

TYLER LUKES

Claimant

- and -

**(1) KENT & MEDWAY NHS & SOCIAL CARE
PARTNERSHIP TRUST**

(2) CHIEF CONSTABLE OF KENT POLICE

Defendants

Eliot Woolf KC (instructed by **Anthony Gold Solicitors LLP**) for the **Claimant**
Harry Trusted (instructed by **Kennedys Law LLP**) for the **First Defendant**
Anne Studd KC (instructed by **Weightmans**) for the **Second Defendant**

Hearing date: **18 October 2023**

Approved Judgment

This judgment was handed down remotely at 10.30am on 15 April 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Mr Justice Julian Knowles:

Introduction

1. This is a case arising out of a claim for personal injury sustained by the Claimant (C) (born 5 September 1999) on 19 August 2020 when he jumped from height onto railway tracks and sustained serious injuries. In the year or so before this incident, and especially in the days leading up to it, there had been concerns about C's mental health, and he had been detained twice in 2019 under the Mental Health Act 1983 (MHA 1983). He had also been arrested by D2's officers for assaulting members of his family. Nothing in this judgment is intended to minimise the loss and suffering of C, his family or friends. Whatever the position in law, everyone accepts that what happened to C was tragic.
2. C has sued the Defendants, namely the Kent and Medway NHS and Social Care Partnership Trust (D1), and the Chief Constable of Kent Police (D2), for negligence. He says they failed to discharge the duties of care which they owed him, and that had those breaches not happened, the events of 19 August 2020 would not have occurred. (I grant D2's application to correct his name on the Claim Form from 'Kent Police' to his proper title).
3. Pursuant to s 88 of the Police Act 1996, D2 is liable in respect of any unlawful conduct of constables under his direction and control in the performance or purported performance of their functions in like manner as a master is liable in respect of torts committed by his servants in the course of their employment.
4. D1 has filed an Amended Defence denying negligence. D2 has not yet done so. Both Defendants have applied to strike out C's claim and/or for summary judgment pursuant to CPR r 3.4 and/or CPR r 24.(3)(a) respectively. D2's applications have been made in advance of him pleading a Defence because he argues that C's Particulars of Claim (PoC) do not contain a factual basis upon which C could reasonably prove a claim in negligence against him, and/or C's case does not have a realistic prospect of success.
5. This judgment uses the following acronyms:

AMHPS	Approved Mental Health Professionals Service (for persons who may require assessment or treatment in hospital for a period of time and cannot agree to this. It arranges and conducts assessment for possible detention under the Mental Health Act 1983)
CJLDS	Criminal Justice Liaison Service (Support service provided by D1 for detainees and defendants in the criminal justice system)
CMHT	Community Mental Health Team (a mental health service offered by D1)
CPN	Community psychiatric nurse
Code C	Revised Code of Practice for the detention, treatment and questioning of persons by Police Officers, issued by the Secretary of State under s 66 of the Police and Criminal Evidence Act 1984

CRHT	Crisis Resolution and Home Treatment team (psychiatric service provided by D1)
IAPT	Improving Access to Psychological Services (GP referral system)
MHA 1983	Mental Health Act 1983
PACE	Police and Criminal Evidence Act 1984
PoC	Particulars of Claim
SLDP	Senior liaison diversion practitioner
SECAS	South East Coast Ambulance Service
SPOA	Single Point of Access (psychiatric support provided by D1)

Background to the claim

6. The essential issue on these applications is whether the facts pleaded by C against D1 and D2 disclose a sufficiently strong cause of action in negligence, capable of giving rise to an award of damages. There has not yet been an exchange of witness statements for trial. The factual background as it currently stands is, instead, derived primarily from the evidence contained within the records mainly (but not entirely) created by both Defendants, as summarised in the pleadings and exhibited to the witness statements made for these applications.
7. I am required to determine the Defendants' applications to strike out on the basis that these assumed facts are true: *CXA v Surrey County Council* [2024] 1 WLR 335, [5]; *Tindall v Chief Constable of Thames Valley Police* [2022] 4 WLR 104, [75]. That said, it must always be borne in mind that there have been no factual findings in these proceedings.
8. So far as the summary judgment applications are concerned, as noted in the *White Book 2024*, [3.4.2], whilst as I have said for the purposes of CPR r 3.4(2)(a) the applicant is generally bound to accept the accuracy of the facts pleaded, in contrast, under CPR r 24.2, where the court is considering whether the case has a realistic prospect of success, the court may be required, without conducting a mini-trial, to examine the evidence that is relied upon to prove the claim and consider the evidence that can reasonably be expected to be available at trial: *MF Tel Sarl v Visa Europe Ltd* [2023] EWHC 1336 (Ch) (Master Marsh).
9. The alleged facts as taken from the pleadings are as follows.

C's prior mental health history

10. C has a family history of mental disorder. His paternal uncle had schizophrenia and died by hanging when he was 21 years old. A maternal cousin took her life. A maternal aunt of C's had bipolar affective disorder.

11. C's mental health issues started to emerge in about 2017/8, when he was approximately 18/19, although he had not 'been himself' since he was about 14 years of age.
12. In 2017/18, C broke up with his girlfriend. He started abusing steroids, used cannabis and occasionally took cocaine and ecstasy. He increasingly suffered from episodes of delusional thoughts, irritability, labile mood, aggression and paranoia.
13. C first came to the attention of mental health services in January 2019. On 24 January 2019 he had to be coaxed from the wrong side of the railings on a bridge by a member of the public. The police attended, but he refused to engage, telling them that he should have jumped. He was found not to be intoxicated or drunk. He was detained under s 136 MHA 1983 (removal of a mentally disordered person to place of safety without a warrant).
14. He was assessed by Helen Quinn, an Approved Mental Health Professional. This is a statutory function created by s 18 Mental Health Act 2007. He told Ms Quinn that what he did was an impulsive act after an argument with his sister; that he regretted his actions; and that he did not need help as he was fine. She considered that he demonstrated good insight into his situation.
15. Following a discussion with the assessing doctors, it was determined that there were no grounds for C's detention, and that hospital admission was not indicated, but that C would benefit from primary care counselling services or relationship therapy. He was discharged home with advice to see his GP who could refer him to IAPT services. He was also given the Crisis team number.
16. On 7 September 2019, C was arrested for allegedly putting his hands around his grandfather's neck in an unprovoked attack, and causing criminal damage by kicking a gate. He was not then detained under the MHA 1983. C's mother took him to the Emergency Department at Darent Valley Hospital, Dartford, as she was concerned by his personality change. He was saying that he wanted to kill himself and was hearing voices in his head. She called the CRHT team and the police for assistance, but was told that they had to wait for the psychiatric liaison team to assess him in the morning. She reported that he was becoming more agitated in the waiting room and was shouting and screaming. He believed he was Jesus and that he had been reincarnated. They left at approximately 20.30 without being seen by the psychiatric team.
17. On returning home, C assaulted his mother and was arrested by the police. Following assessment in custody at North Kent Police Station, he was admitted to Littlebrook Hospital, Dartford, under s 2 MHA 1983 (admission for assessment). He was not treated with any antipsychotic medication. The records state that his mental state gradually improved and there was no evidence of any strange behaviour or psychotic symptoms. He was discharged home on 11 September 2019. Referral to the CRHT was rejected on the basis that there was no active risk documented or acute mental illness. Involvement of the SPOA was similarly declined.
18. C was subsequently assessed by the Dartford, Gravesend and Swanley Mental Health Team on 13 September 2019. It was decided that he would be discharged from their services and referred to the Early Intervention for Psychosis Service, who assessed him on 19 September 2019. It was found there was no evidence of psychosis, grandiosity or

delusional beliefs and as he did not meet their criteria, he was discharged back into the care of his GP.

19. In early 2020, C stopped working for the property management company that employed him on the delusional basis that all those working there were part of a cult and had raped him.

Events in August 2020

20. On 11 August 2020, D2's officers were called to C's home. He was arrested at approximately 16.29 for assaulting his sister and father, criminal damage and assault on an emergency worker. PAVA spray had to be used during the arrest. C was detained in police custody at Medway Police Station from 17.25 onwards. He was described as being 'co-operative' on arrival.
21. The Investigation Summary stated:

"Suspect has assaulted his father and sister, punching his father in the jaw and sister in her left eye. Suspect has then further assaulted an officer whilst resisting arrest, pulling at his arms causing red marks."
22. Following his arrest, C's mother informed the arresting officer, PC Pedrotti, that C had mental health issues; that he had been sectioned in September 2019 and had not been right since; and that while in custody she would like someone from the mental health team to see him, and that he needed medical help.
23. PC Pedrotti reassured C's mother that he would relay all that information to the custody sergeant.
24. However, at 18.03 on 11 August 2020, Detention Officer Grear concluded that C did *not* require an appropriate adult (ie, a person whose role is to safeguard the rights, entitlements and welfare of vulnerable persons whilst they are in police custody); was not in need of medical attention; and was fit to be interviewed. C was placed on Level 1 observations.
25. C's detention status remained the same until 3.29 on 12 August 2020, when Sergeant Dejong conducted a re-assessment of C and wrote (*sic*):

*** APPROPRIATE ADULT REQUIRED**

I have spoken with the OIC regarding the DP and there has been a delay in completing this entry due to custody demand. The victim of this matter are VERY concerned for the DP's mental health. They have detailed that the DP has severe mental health issues and will require at the least an AA but family have requested a MH professional see the DP.

They are concerned as his MH has deteriorated rapidly where the DP has been staring into to a mirror on his own for ages and ‘growling’ at the mirror. DP has previous for trying to kill himself by throwing himself off a bridge. This has not been disclosed by the DP upon being booked in and as such was assessed as not needing an AA. As such all bio-metrics and legal rights were taken without a AA at the time.

Having this new information, failure to act on this could mean a prejudicial outcome for the DP.

The matters in which the DP has been arrested are of a serious nature. With this encompassed with the new information I have – I believe as per the below the DP DOES require an APPROPRIATE ADULT.

I RECOGNISE MY REQUIREMENT UNDER PACE CODE C1.13D TO ASCERTAIN WHETHER THIS DETAINEE IS VULNERABLE

...

I HAVE REASON TO SUSPECT THAT THIS DETAINEE IS VULNERABLE AS DEFINED ABOVE.

The DP although he presents calm, coherent and lucid, the information provided to me is that he suffers badly with MH and this will interfere with the investigation and as such an AA will be needed.”

26. On 12 August 2020 at approximately 11.00, C was seen in police custody by Christopher Parish, a member of D1’s CJLDS. He is a community psychiatric nurse. The Detention Log notes at 11.00: ‘Seen by CPN (SLDP)’.
27. The entry by Mr Parish at 11.34 in D1’s records stated:

“Referred to CJLDS by Medway Police custody having been arrested for alleged assault of a family member. Prior to being seen RIO notes consulted. Tyler is not currently open to mental health services. He was detained under section 136 in January 2019 ...

... Seen in cell. Tyler, on hearing my introduction, immediately told me to ‘fuck off’. I enquired if there was anything at all that I could do to assist him to which he replied ‘No Chris, fuck off. Unless you can get me out of here’. I advised we could talk about what was happening to him and whether he required support on release but he again told me to ‘fuck off’, this time fixing me with a

stare, raising his voice and pointing to the door. I immediately acted on his request and left the cell, closing the door behind me. While agitation/aggression have been indicative precursors to deterioration in his mental state previously there have also been many other factors involved, none of which I have been able to explore. I am unable to speak with his mother or write to his GP without his consent, which he is clearly not going to give to me.

I have left a copy of the CJLDS leaflet with his property to be given on release from custody. I am informed that mother is aware of his arrest and will act as an AA. It seems she is well versed in his difficulties and she has acted in his best interests before. There is no significant risk to self-reported historically, save for the incident that led to his being detained under section 136 but this appears to have been an isolated incident.”

28. Although not in the PoC, this entry by Mr Parish finished:

“There is no further role for CJLDS at this time.”

29. Notwithstanding that entry, at 14.37 on 12 August 2020, C was seen again by Mr Parish. The Custody Record states:

“Repeat effort made to assess. DP continues to decline my offer of assessment. DP also declined consent to me to speak with his mother”

30. At 15.29, C was deemed fit to be interviewed on the basis that his mother was now present as an appropriate adult. He went to interview at 15.36 and returned at 16.44.

31. The pre-release risk assessment was completed at 17.12 by Temporary Sergeant Synczysz. This recorded that C was at no heightened risk of suicide or self-harm following release; was not suffering from any mental health issues; was not a vulnerable adult; was at no risk to himself or others following release; there was no healthcare advice to be provided to him or his parent upon release. He was released on bail at 17.14.

32. On 15 August 2020, C was visited by his father, Marcus, at the hotel where his father had placed him out of concern for the safety of his family at home. His father called D1’s CRHT team at 12.12. The entry in the records stated:

“Received a call from Tyler’s dad (Marcus) stating that they visited their son at the hotel where they placed him after he was arrested for assault on family members. Marcus stated that they called the police after Tyler assaulted his sister. According to Marcus, he feels that Tyler would be worse on his own as he seems to be having mental health issues. Marcus was given SPOA contact

details. Marcus would like to bring Tyler home but he is worried that he might fight his sister again. Marcus was advised to call the police if Tyler becomes aggressive. Plan: Marcus to contact SPOA. Marcus to contact [general practitioner].”

33. C’s father duly made contact with D1’s SPOA Team. The entry at 12.41 on 15 August 2020 by a Ms Pinduke stated:

“Phone call from Marcus Lukes father (*sic*). He expressed concerns for Tyler’s mental health. He was worried about making the referral as he did not want Tyler to know that he had made the referral as Tyler will believe that family are ganging up against him. Advised that Tyler has seen CJLDs in last few days and that our clinicians are very tactful when calling someone who is referred. If Tyler is aware that family have called SPOA it would seriously affect the family relationship considerably. Marcus initially asked for services to support Tyler when he gets eventually home. Tyler has been aggressive to his father and sister so Marcus wants to ensure that his daughter is settled elsewhere before Tyler comes home. Marcus explained that when Tyler was 19 years old he took a lot of steroids along with drugs before EIS input. Marcus believes that Tyler does not take drugs now or drink alcohol but is completely withdrawn. He has isolated himself staying in his car. Marcus has now paid for Tyler to stay in a hotel. He is not eating properly. Paranoid about banks, he will not pay a cheque in as he is suspicious. He is talking to himself. Laughs to himself. He was beaten up badly just before his hospital admission. Marcus has concerns for the safety of Tyler as he is unpredictable.”

34. A call was made by Clare Hatfull of SPOA at 18.32 on 15 August 2020 and answered by C, following which he was discharged. A screening form completed by Ms Hatfull ticked that C was not known to local mental health services or other agencies, there was no history of mental illness in the family and he had never attempted suicide. A box relating to self-harm and risk to others was not completed. Ms Hatfull’s notes stated:

“Referred by his Father (Do not disclose referrer to Tyler)

FIRST ATTEMPT to make contact and the call rang and was answered by Tyler, he said he was absolutely fine and did not want any support with his mental health. He asked that no more calls be made to his number. Declined triage. Discharged from SPOA.”

35. On 18 August 2020, the SPOA wrote a letter stating that as a result of not being able to contact C on 15 and 16 August 2020, his referral had been closed to the service. It said if he required their service, he was to contact the team within three days of receipt of

the letter or contact his GP. (The PoC aver that for the avoidance of doubt, C will say that the SPOA made contact with him on 15 August 2020 but not on 16 August 2020).

36. On 19 August 2020, C's behaviour became increasingly agitated at home. He could not sleep, and threatened violence towards his family. After taking a hammer from the garage and going to a neighbour's house, the police were contacted.
37. At 11.40 that day, a 999 call was made to SECAS by C's mother, requesting an ambulance. During the call, C's mother described her son as 'having a psychotic attack. Talking nonsense, irritable and shouting. Trying to leave property with his car keys. Ambulance dispatched.' She further explained that she was 'locked in the bathroom with her partner outside trying to calm the patient down, as he was trying to leave the property with his car keys'. C could be heard shouting in the background. Details of C's MHA 1983 section history were also provided.
38. C's mother also spoke to C's GP, Dr Abdul Halem. The GP's records note:

"Has now called ambulance – having psychotic episode – noted father had tried to contact SPOA on 15th – ambulance on way. Priority = 6."
39. A Kent Police Incident Report suggested that the police were contacted at 11:46. An entry timed at 11.47 stated:

"The family are a high risk MARAC [Multi-Agency Risk Assessment Conference] family Object due family members being assaulted by Tyler Lukes who has a history of mental health... Son is kicking off - he could be heard screaming and shouting in the background.. mum has locked herself in the bathroom because of this - for safety reasons. Tyler appears to be suffering with a MH episode. the father is in the property trying to calm Tyler down ... The mother said he is trying to run out the property. Not got any weapons as far as they know."
40. The ambulance arrived on the scene at approximately 11:57 and the presenting complaint was noted as follows:

"Patient has been upset and angry today according to parents shouting and proclaiming to be God, patient took a hammer and knocked on the neighbour's door apparently to do some building work? Patient has been making cocktail bombs in a bottle? As he believes there are enemies after him. Patient believes anyone wearing red is the devil. Patient was sectioned one year ago and was released without medication? Patient's mother and father are scared to be left alone with patient as they feel they will be killed in their sleep by patient.

Psychiatric

Harm: No Harm.

Behavioural: Patient acting calm, appeared intelligent in the way he spoke, acting as if nothing is wrong, although from the things patient was saying became quite apparent there is mental health issues and patient possibly psychotic.

Patient has extremist views and could quite easily be radicalised and is vulnerable to this therefore crew have completed an online form for reporting radicalization report number 80H- 1719- 20-0100- 000.

Patient does not state to be suicidal although parents state patient was suicidal last week? Patient is no harm to himself.

Psychiatric/Mental health notes

Patient stating to be god and can heal himself, believes the police cannot enforce fake rules and people should not be forced to work. Patient appears to have some sort of mental health issues however has capacity and does not want any help or to attend A&E

Secondary survey notes

Spoke to patient GP which was on duty DR who stated patient has been contacted by the CRISIS team on 15 August and another service not long before that however both times patient has stated they do not want any help. GP advised for patient to contact CRISIS team as the GP surgery will not send a DR out for home visits and patient refused to go to surgery to see a DR. Police attended scene and believe patients extremist views and behaviour could stem from a previous incident where patient was beaten and attacked in public ...

... Patients parents state the mental health issue has been on going now for nearly 2 years. Patient was not aggressive on scene police unable to act on anything as patient did not need sectioning and had not committed a crime ...

Non-conveyed. Reason The patient requires assistance only / medical attention which has been provided by Ambulance staff.”

41. C's GP, Dr Halem, was contacted by the paramedics. The entry in the GP records stated:

“Third party encounter spoke to paramedic Rose at scene - patient was aggressive and went with hammer to neighbour- police called (sic) but as no action as he was a (sic) calm they did not arrest and not for section he was last sectioned (sic) in nov-no rx parents thing (sic) he is being radicalised and claiming about God etc. Advised paramedic best for admission to A&E to see duty (sic) psychiatrist (sic) but patient refusing - he can also contact crisis team.”

42. Further entries in the police records at 12.06 onwards stated:

“Have been able to speak to dad, who is concerned that Tyler has not been behaving. No offences, this has just been a MH ep, refused to answer. Tyler is currently with paramedics, and dad has stated that he seems to be responding well. Going to stay on scene, to ensure AIO. XTL noted and aware patrol state 6 not actively monitoring. This is not a domestic, further clarification from mother and father is that Tyler is suffering from mental health. They called SECAMB for assistance for this. There has been no argument which was confirmed by all parties in the property, as such no offences, no domestic has taken place.

Paramedics spoke to Tyler who stated that he did not want or need medical attention, however permitted the paramedics to liaise with his doctor in relation to mental health concern. Paramedics confirmed that Tyler has capacity so are limited in what they can do. Officers spoke to Tyler and requested his permission to place an AP referral on him to help him engage with services, however Tyler refused. Tyler did make comments to police and SECAMB stating somewhat extreme views, regarding how the world is run and human should not be labelled as numbers. Officers on scene liaised with paramedics who confirmed that some form of mental health is taking place here, however if Tyler has capacity, they are limited in what they can do if Tyler refuses help, same as police. Officers have confirmed that all that can be done is place an intel report on in relation to what Tyler has stated, and paramedics have confirmed they will log this incident via one of their channels.”

43. At 14.24, the paramedic contacted D1's SPOA team. The entry stated:

“Parents contacted the ambulance service as they are concerned regarding his mental health. They said Tyler has not been sleeping and does not want to leave the house. His mum describes Tyler’s behaviour as erratic and said she is scared of him. Tyler is willing to engage with mental health services.”

44. At 15:01 C was duly referred to the SPOA team with a request for review within 24 hours. The referral was reviewed by the SPOA team at 15.01. The entry stated:

“Urgent SECAMB referral reviewed. SECAMB requesting 24 hrs response, Tyler recently declined our service, parents are concerned and they report he is ready to engage? Parents reports erratic behaviour and reports they are scared of him? RAG status: Amber. Plan: Due to risks identified SPOA to attempt contact within 24 hours. Added to SPOA priority list”.

45. Telephone contact was made by the SPOA. An entry timed at 20.05 (but said in the PoC likely to have been earlier) stated:

“... his mother answered the phone and I explained who I was and she then tried to get Tyler to answer the phone. After about 10 minutes of me hearing his mother and father encouraging Tyler to answer the phone he came to the phone. Tyler informed me that he didn't want anything to do with the assessment. I explained to Tyler that people are concerned about him and he informed me ‘all I want to do is sleep’. Tyler then reported that when he walks down the street and he stops members of the public why are people rude to him. Tyler continued to state that he then keeps all is angry inside until he is home. Tyler did state that this is making him feel sad but he also reported that he has no thoughts of self harm or suicidal ideation. I then asked him what he did once home with the angry and he refused to disclose. I enquired if Tyler was currently taking any medication to which he reported he is not. I again asked Tyler if he would take part in the assessment to which he declined and became angry towards me.

... Tyler is a 20 year old gentlemen who has a diagnosis of drug induced psychosis and looking at the notes Tyler is currently relapsing and will require a face to face duty appointment by the local CMHT (DGS). Tyler has refused to engage with this assessment due to his deteriorating mental health state.

Urgent referral. The plan: 1) Tyler is discharged from SPoA caseload and transferred to the local Cmht (DGS) for an urgent assessment due to reported deteriorate

mental health state. 2) Tyler has a diagnosis of drug induced psychosis. 3) Tyler will require a face to face assessment and due to his hx of non-engagement he will require a home visit so that the assessment can take place. 4) Tyler is currently on no medication.”

46. Following the call with the SPOA, a 999 call timed at 20.02 was made by C’s mother requesting an ambulance and reporting that C had just got into his car and driven off. The call handler advised her to contact the police as the ambulance service could not help as there was no confirmed location for him.
47. C’s mother contacted the SPOA at 21.23 to report that he was ‘out driving and has been reported to the police who are currently looking for him.’
48. At 22.06 the SPOA Team referred the patient to the CMHT (DGS, that is Dartford, Gravesham and Swanley) for review, citing that since their telephone review, C’s mother had contacted them raising concerns for his immediate safety. The SPOA Team suggested that C’s mother contact the police in the first instance and that there was ‘no further role for the SPOA’.
49. SECAMB received a second 999 call at 22.07 reporting that C had fallen from a bridge and landed on the railway tracks. The entry stated:

“...Pt fell/jump from a bridge (>25ft) and landed (feet first) on the railway tracks. Pt has not moved since the fall ...”
50. An ambulance crew was allocated to the scene at 22.17 and was at his side by 22.23. C was admitted to intensive care at King’s College Hospital.
51. As a result of his fall, C sustained severe spinal and other injuries; it is not necessary to go into the details. He is now wheelchair dependent indoors and outdoors.

Chronology

52. A short timeline of events up to the time of the accident is therefore as follows:

January 2019 C detained under by police under s 136 MHA 1983 following being coaxed from railings on bridge. On examination by the AMHP he was discharged into the community. No evidence of psychosis etc found.

September 2019 C arrested for assault and admitted to hospital from custody under s 2 MHA 1984. Not treated with antipsychotic medication. No psychotic symptoms found. Also found to be at no active risk and not suffering from acute mental illness.

Assessed following release (after four days detention) by the Early Intervention for Psychosis Service. No evidence of psychosis, grandiosity or delusional beliefs found. Discharged back into the care of his GP.

- 11.8.2020 C arrested for assault and detained in Medway police station. He appears calm, coherent, and lucid on arrival. He does not give any indication that he is suffering with mental health issue
- 12.8.2020 *Early hours:* the Custody Officer receives information from C's family that they are worried about his mental state. The Custody Officer makes an entry in the Custody Record; revises the assessment; and arranges for the appointment of an appropriate adult in accordance with PACE Code C, and for him to be examined by an appropriate health professional in the police station.
- Morning:* Mr Parish, a community mental health nurse employed by D1's CJLDS as an SLDP, seeks to speak to C in custody and to carry out a mental health assessment. C makes clear he does not wish to be examined by Mr Parish and tells him to 'fuck off' a number of times. He refuses consent for Mr Parish to speak to his mother. He includes details of C's history in a Custody Record entry at 11.00.
- Afternoon:* Mr Parish again attempts to assess C, but C declines again and again refuses consent for liaison with his mother.
- C assessed as fit for PACE interview
- C interviewed with mother present as appropriate adult. Also has assistance of solicitor, with whom he had consulted before the interview. No issue raised about C's fitness for interview. Interview concluded
- Evening:* police conduct pre-release risk assessment. No risks identified
- C is released on conditional bail at around 17.14. Goes to live with cousin, but moves to hotel shortly after, paid for by his father.
- 15.8.2020 Contact with CRHT and SPOA. C refuses assistance, says he is fine, and says he does not want any more phone calls.
- Ms Hatfull completes screening form.
- C discharged from SPOA.
- 19.8.2020 Police are contacted as a result of a 999 call. C is reported as having a mental health episode, but matters were being dealt with by medical colleagues, therefore no attendance. Numerous discussions between various persons about C's mental health. He is assessed as having capacity. Plan made for an urgent home assessment under MHA 1983.
- 19.8.2020 999 call. Police begin searching for C due to concerns about his welfare.

Subsequently it transpires that C has jumped from a bridge and sustained serious injuries. C admitted to King's College Hospital.

C's case against each Defendant

The pleaded case against D1

53. D1 was responsible for the provision of secondary mental health services across Kent and Medway, both in the community and within inpatient settings.
54. Each of the clinicians and nursing staff employed by D1 owed C a duty of care in respect of the treatment, care or services provided by them and D1 is vicariously liable for any breach of duty by them.
55. It is alleged that D1's management of C's clinical and personal care was in breach of duty, as follows (PoC, [34(i) and (ii)]).
56. On 12 August 2020 by Mr Parish:
 - a. he failed to pay any or any sufficient regard to C's mental health history. In particular, determined that the C had no significant risk of self-harm historically save for a single prior detention under s 136 MHA 1983, when his past history was wholly consistent with a significant risk of self-harm to himself 'or others' (*sic*);
 - b. he determined incorrectly that he was unable to speak with C's mother or write to his GP to find out more information about his mental health without the Claimant's consent;
 - c. he failed to carry out any meaningful assessment or screening process to determine if C was or remained at a significant risk of self-harm to himself or others;
 - d. he failed to ensure that C underwent a competent and effective psychiatric assessment either voluntarily or under the MHA 1983.
57. On 15 August 2020 by Ms Hatfull:
 - a. she failed to undertake an appropriate or effective screening assessment;
 - b. she recorded that the C was not known to mental health services or other agencies, that there was no history of mental illness in the family and he had never attempted suicide; concluded that there was no psychosis present, notwithstanding the clear evidence of psychotic symptoms in the prior entry by Hazel Pinduke;
 - c. she discharged C from the SPOA on the basis that he reported he was absolutely fine and did not want any support, notwithstanding the known history of aggression by him to his family; the fact that he had been placed in a hotel for the family's safety; he was paranoid and talking to himself; his father had concerns for his safety due to his unpredictability;
 - d. she failed to ensure urgent same day referral to and review by the CRHT Team.

58. In relation to causation as against D1, this is addressed at [37] and [39] of the PoC as follows:

“37. On the balance of probabilities, had the First Defendant through Mr Parish carried out an appropriate and responsible assessment on 12th August 2020, he would or should have determined that the Claimant required an immediate psychiatric assessment by the CRHT that day who in turn would have involved the Approved Mental Health Professional Service (‘AMHPS’). In circumstances where the Claimant revealed florid thought disorder such as believing he was Jesus and presented significant risk to himself and his family, he would and should have been kept in custody until he was assessed by AMPHS. Upon assessment, he would have been admitted to hospital either as a voluntary patient or in the event of refusal, as a detained patient under Section 2 of the Mental Health Act. He would have been commenced on antipsychotic medication and kept under close review and assessment. The subsequent deterioration leading to his episode of self-harm on 19th August 2020 would have been avoided. He would have made a reasonable recovery with relative stability, but would have been at risk of further relapses in the future.

...

39. A similar management process and outcome would have followed to that above had the Claimant’s undergone an appropriate assessment on 15th August 2020. The Claimant would and should have been directly referred to AMHPS by Ms Hatful or to the CRHT. Upon same day assessment, he would have been admitted to hospital either as a voluntary patient or in the event of refusal, as a detained patient under Section 2 of the Mental Health Act. The outcome and long-term prognosis would have been the same as above.”

The pleaded case against D2

59. D2 is responsible for the provision of police services in Kent. C has pleaded the duty of he says D2 owed as follows (PoC, [1(iv)]):

“(iv) each of the clinicians, nursing and/or police staff employed by the Defendants owed the Claimant a duty of care in respect of the treatment, care or services provided by them and the Defendants are vicariously liable for any breach of duty by them.”

60. D2's management of C on 11 and 12 August 2020 was in breach of the duty he owed C in that by its servants or agents, he (PoC, [35]):
- a. failed between 18.03 and 3.29 on 11/12 August 2020 to determine that C required an appropriate adult, was in need of medical attention (on account of his mental ill health) and was unfit to be interviewed;
 - b. having determined at 3.29 on 12th August 2020 that C required an appropriate adult, failed to ensure that C underwent an appropriate and effective mental health assessment by a Healthcare Professional to determine if he was fit to be interviewed in accordance with Code C of the Police and Criminal Evidence Act 1984 (PACE) and the College of Policing Authorised Professional Practice;
 - c. upon Mr Parish of the CJLDS failing or being unable to undertake any mental health assessment, failed in any event to ensure that C underwent an appropriate and effective psychiatric assessment by a Healthcare Professional in accordance with the requirements of Code C of PACE;
 - d. failed to carry out a competent pre-release risk assessment. In particular, recorded that C was at no heightened risk of suicide or self-harm following release; was not suffering from any mental health issues; was not a vulnerable adult; was at no risk to himself or others following release; and that there was no healthcare advice to be provided to him or his parents upon release.
61. In relation to causation, [38] of the PoC avers (referring back to [37] – see above):

“38. A similar management process and outcome would have followed to that above had the Second Defendant ensure that the Claimant underwent an appropriate assessment by a Healthcare Professional on 12th August 2020 as it should have done.”

D1's Amended Defence to the claim

62. D1 denies that C suffered at the material time from any severe enduring mental illness such as schizophrenia, bipolar affective disorder or severe depression. It relies on the following.
63. A diagnosis of drug-induced psychosis (ie, psychosis induced by a combination of cannabis and steroids) was considered during the admission to Littlebrook Hospital in September 2019. However, there was no evidence of psychosis, grandiosity or delusional beliefs on discharge on 2 October 2019, and C did not meet the criteria for early intervention psychosis services. Consequently C was discharged without medication and his GP was advised accordingly.
64. Following his fall, on 3 September 2020 C was reviewed by a psychiatric consultant, Dr Kam, at King's College Hospital. He wrote that:

“Consideration was given whether there was underlying personality traits especially in context of past history.

However, at present there is limited evidence of said traits impacting upon his health care needs. He is warm and engaging and is working well with the treating team at present. At present there is not acute thoughts of harm to self or others at present. Consideration was given whether this was a primary psychotic disorder. However, the rapid resolution of his symptoms without psychotropic treatment makes it less likely. Working diagnosis at present is either 1. Acute stress reaction in the context of recent break up 2. Unspecified mental and behavioural disorder secondary to psychoactive substances ...”

65. The discharge report from the South London and Maudsley NHS Foundation Trust dated 7 September 2020 reported that C said he had jumped off the bridge:

“... in an impulsive [act] immediately following a phone call with his partner where she had ended the relationship. His previous episode of suicidality was precipitated by similar breakdowns in relationships.”

66. During his admission following his fall, he showed psychotic symptoms in ICU, however this was thought to be due to the large amount of opioid analgesia and other dissociative medication he was on at the time. Following his ‘stepdown’ to a ward, C was not observed to show any symptoms of psychosis during the two weeks that the psychiatric team regularly reviewed him. He was also reviewed by a clinical psychologist. The discharge report said:

“Mr Lukes also displayed no symptoms of depression or suicidality during his admission, while he was at times upset and often tearful about his circumstances. This is understandable and a normal reaction of loss of function of one limb. He consistently reported he was keen for future therapy and rehabilitation and had plans for the future. Given his current presentation and previous behaviour, the possibility of either a psychotic relapse or an underlying emotionally unstable personality were considered. However, as ultimately the circumstances surrounding his admission were not ever made entirely clear and as Mr Lukes displayed no symptoms of psychiatric illness at all while admitted, we decided that his presentation was most likely due to the presence of an acute stress reaction to his relationship desolation. He was eventually repatriated to Darent Valley Hospital and his psychiatric care was handed over to the team there...’

67. Paragraph 17(e) avers that when assessed by the Dartford Liaison team at the Darent Valley Hospital on 10 September 2020, C himself described the jump from the bridge as impulsive and recalled that the first time he attempted to commit suicide, he had just broken up with a girlfriend, lost his job and fallen out with close friends. On review on 15 September 2020 the note states:

“There was no evidence of any mood disorder or any formal thought disorder. He was not observed to be responding to any abnormal stimuli. He was orientated to time, place and person. Tyler demonstrated insight into the event and capacity for decision making.

Plan 1. No evidence of any mood disorder/psychosis at present, therefore psychotropic medication is not currently indicated. 2. No current need for DOL/Section 5(2) at present, no evidence of acute mental disorder. Ongoing liaison review to monitor mood and mental state. 4. Awaiting bed at Stoke Mandeville. 5. Update risk assessment ...”

68. In relation to the alleged breaches of duty, D1 contends that:
- a. Regarding the criticisms of Mr Parish, he was entirely accurate in describing C’s mental health history; he determined correctly that he could not speak to C’s mother or write to his GP without C’s consent; he could not carry out any meaningful assessment or screening process if C refused to cooperate, and there was no basis for compulsory detention under the MHA 1983.
 - b. Regarding the criticisms levelled against Ms Hatfull, D1 contends that Ms Hatfull could not undertake a appropriate or effective screening assessment if C refused any assistance; he was not psychotic in fact; she had no option but to respect his wishes to avoid further contact with SPOA; and there was no further basis for referral and referral by the CRHT.
69. In relation to causation arising from Mr Parish’s alleged breaches:
- a. It is denied that it was possible for Mr Parish to carry out any assessment beyond that which he did on 12 August 2020. If, contrary to that, it be held that Mr Parish should have assessed C differently, it is denied that any such assessment would have resulted in a determination that C required an immediate psychiatric assessment by CRHT and the AMHPS as alleged or at all.
 - b. If such a psychiatric assessment by CRHT/AMHPS had occurred, it is denied that C would have been admitted to hospital as a voluntary patient in view of his persistent and documented refusal to co-operate with the medical support offered at this time (including telling Mr Parish to ‘fuck off’ several times).
 - c. If a psychiatric assessment by CRHT/AMHPS had occurred, it is denied that the conclusion of any such assessment would have been the C’s compulsory detention pursuant to s 2 MHA 1983 as alleged or at all.
 - d. It is denied that at any material time between 12 August and 19 August 2020 the Claimant suffered from psychosis as alleged or at all.
 - e. Consequently it is denied that even if the Claimant had been admitted to hospital following assessment by Mr Parish, C would have been given anti-psychotic medication as alleged or at all.

- f. Further, even if, contrary to the above, the C had been admitted to hospital (either voluntarily or under compulsion), he would have remained an in-patient for no more than a few days at most and then resumed his consumption of illicit substances. Further, he would have had a deteriorating relationship with his family and his girlfriend. For this reason, admission to hospital on or about August 12th 2020 would have done no more than postpone by a few days C's fall from the bridge on August 19th in any event.
70. Therefore, D1 denies that the episode of self-harm on 19 August 2020 would have been avoided as alleged or at all but for any alleged negligence on the part of Mr Parish.
71. As to the causation allegations in [39] of the PoC arising from Ms Hatfull's alleged defaults:
- a. It is denied that it was possible for Ms Hatfull to carry out any assessment beyond that which she did on 15 August 2020. If, contrary to that, it be held that Ms Hatfull should have assessed C differently, it is denied that any such assessment would have resulted in a determination that C required an immediate psychiatric assessment by CRHT and/or the AMHPS as alleged or at all.
 - b. Had there been such a referral, it is denied that C would have been admitted to hospital as a voluntary patient in view of his persistent and documented refusal to co-operate with the medical support offered at this time. When Ms Hatfull spoke to the Claimant on 15 August 2020, he made it clear that he did not wish to accept the psychiatric support that SPOA offered. If a psychiatric assessment by CRHT/AMHPS had occurred, it is denied that the conclusion of any such assessment would have been C's compulsory detention pursuant to s 2 MHA 1983 as alleged or at all.
 - c. It is denied that at any material time 12 and 19 August 2020 C suffered from psychosis as alleged or at all.
 - d. Consequently it is denied that even if C had been admitted to hospital following assessment by Ms Hatfull, he would have been given anti-psychotic medication as alleged or at all.
 - e. Further, even if, contrary to the above, C had been admitted to hospital (either voluntarily or under compulsion), he would have remained an in-patient for no more than a few days at most and then resumed his consumption of illicit substances. Further, he would have had a deteriorating relationship with his family and his girlfriend. For this reason, admission to hospital on or about August 15th 2020 would have done no more than postpone by a few days the Claimant's fall from the bridge on August 19th in any event.
 - f. For the avoidance of doubt, if contrary to the pleading in [18(b)(ii)] of the Amended Defence, it be held that Ms Hatfull completed the form in breach of duty, it is denied that any such breach was causatively relevant.
72. Hence, D1 denies that the episode of self-harm on 19 August 2020 would have avoided as alleged or at all but for any alleged negligence on the part of Ms Hatfull.

73. In any event, from the point of view of causation, there was no evidence that he was ever psychotic when he was subsequently admitted to hospital after the incident of self-harm.

Submissions on these strike out/summary judgment applications

74. I will now summarise the parties' submissions on these applications in the order I was addressed.

Submissions by D2

75. Ms Studd KC for D2 submitted as follows.
76. She accepted that D2 owed C a duty of care whilst in custody: see *Kirkham v Chief Constable of the Greater Manchester Police* [1990] 2 QB 283; *Reeves v Commissioner of Police for the Metropolis* [2000] 1 AC 360. I will return to these cases later.
77. Ms Studd took me through the events between 11 August 2020 and 19 August 2020. She said that the steps which D2 was required to take vis-à-vis C to fulfil its duty of care towards him were those contained in Code C.
78. Ms Studd accepted that D2 might arguably have been at fault in failing to identify C as possibly suffering from a mental disorder upon him being assessed following his arrival at the police station on 11 August 2020, given what his mother had said to PC Pedrotti. However, importantly, Ms Studd said that that (assumed) failure had been 'cured' by the revised assessment at 3.29 by Sergeant Dejong, which did identify C's vulnerabilities and led to his mother's attendance as an appropriate adult and also Mr Parish's attendance. For this reason alone, this alleged breach was not causative of anything.
79. She said that once C had been identified as having mental health issues, D2's duty *per* [9.5], [9.5A] and [9.8] of Code C was to ensure he received 'appropriate clinical attention':

“9.5 The custody officer must make sure a detainee receives appropriate clinical attention as soon as reasonably practicable if the person:

- (a) appears to be suffering from physical illness; or
- (b) is injured; or
- (c) appears to be suffering from a mental disorder; or
- (d) appears to need clinical attention.

9.5A This applies even if the detainee makes no request for clinical attention and whether or not they have already received clinical attention elsewhere. If the need for attention appears urgent, e.g. when indicated as in Annex

H, the nearest available healthcare professional or an ambulance must be called immediately.

...

9.8 If a detainee requests a clinical examination, an appropriate healthcare professional must be called as soon as practicable to assess the detainee's clinical needs. If a safe and appropriate care plan cannot be provided, the appropriate healthcare professional's advice must be sought. The detainee may also be examined by a medical practitioner of their choice at their expense."

80. A 'health care professional' is a defined term in Code C. Note 9A provides:

"9A A 'healthcare professional' means a clinically qualified person working within the scope of practice as determined by their relevant statutory regulatory body. Whether a healthcare professional is 'appropriate' depends on the circumstances of the duties they carry out at the time.."

81. Paragraph 5 of Annex E to Code C provides:

"5. The custody officer must make sure a person receives appropriate clinical attention as soon as reasonably practicable if the person appears to be suffering from a mental disorder or in urgent cases immediately call the nearest appropriate healthcare professional or an ambulance. See Code C paragraphs 3.16, 9.5 and 9.6 which apply when a person is detained under the Mental Health Act 1983, sections 135 and 136, as amended by the Policing and Crime Act 2017."

82. Paragraph 4 of Annex G provides:

"4. It is essential healthcare professionals who are consulted consider the functional ability of the detainee rather than simply relying on a medical diagnosis, e.g. it is possible for a person with severe mental illness to be fit for interview."

83. The College of Policing's Appropriate Professional Practice in relation to Detention and custody risk assessment says:

"Condition of the detainee

Officers should seek advice from an appropriate HCP [healthcare professional] if they have concern that a detainee has an injury, medical condition or a mental

illness, appears to be experiencing mental ill health or otherwise requires medical attention. This does not apply to minor injuries or ailments, but officers should still note those in the custody record. If unsure of the nature of a condition, officers should call an HCP. See PACE Code C paragraph 9.5 and Notes for Guidance, Note 9C.

...

Custody officers need to be aware of the enhanced risk of suicide and self-harm during periods of detention. Detainees who are deemed to be a high risk of suicide or self-harm must be seen by an HCP and kept under close proximity supervision. This allows officers and staff to engage with the detainee and intervene if required

... ”

84. Ms Studd said D2 fulfilled his Code C duty of ensuring C received ‘appropriate clinical attention’ by contacting Mr Parish, who as a community psychiatric nurse, was a ‘health care professional’ within Note 9A. She pointed out that this is different from an approved practitioner under s 12 MHA 1983, who can authorise compulsory detention under the Act. They must be a doctor, which Mr Parish was not.
85. As recorded in the Detention Log, Mr Parish attended as a SLDP. Ms Studd took me through the duties of an LDP practitioner like Mr Parish (as set out in the NHS’s standard contract), which include: carrying out screening of those detained in police custody with mental health needs, and identifying what further assessments might be necessary (eg by an approved medical practitioner under s 12 MHA 1983 with a view to compulsory detention). She said that on the facts there was no requirement in this case for D2’s officers to have done more than they did to fulfil their duty of care and that they were entitled to rely upon Mr Parish’s assessment.
86. In this regard, [2.8.3] in the contract states:

“2.8.3 Exclusion criteria

The following functions will not be pursued as part of the L&D service:

- removal and detention of an individual in accordance with section 136 of the Mental Health Act 1983
- street triage services
- fitness to detain, fitness to interview and pre-release risk assessments
- mental Health Act assessments
- custodial in-reach services or post release services.

However, it will be important for providers of L&D services to build interfaces with providers of the above functions. This service will also address the sharing of relevant flows of information with those providers, to ensure that any relevant diagnoses are made known for the purposes of access to appropriate health and social care services.”

87. Ms Studd said C’s case was really that D2’s officers should have ‘gone over Mr Parish’s head’ once he had been unable to carry out an assessment because of C’s attitude. She said that in this case there had been no basis for doing so. She accepted that there might be an exceptional or extreme case where the attendance of an LDP, and even one clinically qualified like Mr Parish (an LDP does have to be medically qualified), might not be enough to fulfil D2’s duty, but that was not this case. D2’s officers had done what Code C required them to do, and they were entitled to rely upon Mr Parish’s actions. It was not alleged or pleaded that the police themselves should have utilised their powers under s 136 to detain C (as had happened in January 2019).
88. As for the alleged breach of duty arising from the pre-release risk assessment not having recorded any particular risks, Ms Studd said that C had been dealt with at least twice by mental health services in the week following his release, and so no later than then they had assumed care for C’s in relation to his mental health, and so any breach was not causative of what happened 19 August 2020.
89. She therefore said that C’s case was unarguable against D2 and so should be struck out and/or summary judgment granted.

Submissions by D1

90. On behalf of D1, Mr Trusted submitted as follows.
91. He said C’s claim as against his client was one, effectively, of clinical negligence. He said, per *Hewes v West Hertfordshire Hospitals NHS Trust* [2018] EWHC 2715 (QB), a clinical negligence case, where Foskett J said that successful strike-out applications in clinical negligence cases were virtually unknown, that whilst that might be the case, there was no rule why a sufficiently weak case should not be struck out. This was such a case.
92. Further, whilst C had referred to the possibility of expert evidence that Mr Parish had been negligent to advise the police that C posed no risk to self-harm (see eg, Skeleton Argument, [26]), any court would be bound to reject such evidence as illogical and unsupported: cf *Bolitho v City and Hackney Health Authority* [1998] AC 232, 243C-E.
93. D1’s case is that appropriate care was provided to C and that there is no basis upon which any court could find breaches of duty or causation, as alleged or at all.
94. Mr Trusted took me through the history. He emphasised that no psychosis had been found in January 2019 and C had merely been advised to see his GP. Mr Trusted then moved to events *following* C’s injury on 19 August 2020. He referred me to the assessments in early September 2020 which I set out earlier and which are quoted in the Amended Defence. These did not report psychosis. He also referred me to the Darent

Valley assessment of 10 September 2020 which found no evidence of psychosis and that psychotropic medication was not indicated.

95. Turning back to August 2020, Mr Trusted emphasised that at no point did C lack capacity, and that he was repeatedly uncooperative with attempts to assist him, including by Mr Parish and Ms Hatfull. He reminded me of the latter's call with C on 15 August 2020 when C told her was 'absolutely fine' and declined triage.
96. Mr Trusted therefore said orally in relation to C's 'no doubt seven-figure claim', that 'standing back':

“... those were the contacts upon which he seeks to assert his claim against D1 ... in circumstances where he has capacity, and plainly refused any kind of assistance, it is difficult to see how or why D1 and their employees should be landed with any finding of liability.”
97. Mr Trusted then turned to causation against D1 and [37] of the PoC. He said even if (which is denied) there were breaches of duty for which D1 is responsible, C's case failed on causation in any event. The nub of C's case is that if the breaches had not occurred by those for whom D1 was responsible, he would have gone into hospital (voluntarily or compulsorily) and not been able to injure himself
98. Mr Trusted said that C would obviously not have agreed to admission voluntarily and there was no arguable basis in the evidence for a compulsory admission as he was not psychotic.
99. Mr Trusted also said that even with a limited and brief admission of C as a patient, the outcome would have been the same, given, for example, that C's declared reason for jumping was the breakup with his girlfriend. That would almost certainly have happened in any event.
100. In relation to breach, Mr Trusted's overarching point was that given C's attitude of non-cooperation and refusal to engage, and his capacity, neither Mr Parish nor Ms Hatfull had been negligent. Mr Parish had been aware of and correctly noted C's background of self-harm; he had rightly determined he could not speak to C's mother or GP in light of his refusal of consent, and even if he had, little would have been gained; he could not assess C without his consent. Ms Hatfull had not, on the information available to her, completed the screening form incorrectly and had been right to discharge C in light of his expressed wishes and attitude and he did not want to be triaged.
101. Mr Trusted concluded by saying that whilst the facts of the case are tragic, the reality is that C did not wish to co-operate with either Mr Parish or Ms Hatfull or benefit from the psychiatric services which D1 attempted to offer him. C was entitled to make those choices, but neither Mr Parish nor Ms Hatfull did anything wrong, and no liability can attach to D1. C's case is so weak that it should be struck out or summarily be disposed of now.

Submissions by C

102. Mr Woolf began by submitting that these applications were unusual in that there were no particular issues of law involved. The applications were based on the facts. On the *Hewes* point, he said there was no inflexible rule that summary judgment could not be granted in cases like the present involving clinical matters. But he emphasised that there was no expert evidence as yet, and that D1's and D2's submissions were really ones which needed to be the subject of such evidence (eg as to C's proper diagnosis in August 2020, and whether he ought to have been further assessed and sectioned). He also said the issue of causation necessarily could only be resolved on the basis of expert evidence. He said the Ds' applications required me to reach judgments on incomplete factual evidence and that I should be very hesitant before summarily determining C's claim against him.
103. As against D2, Mr Woolf said there was no particular issue between the parties about the extent of D2's duty of care. He said the police had been in breach of that duty because they should have ensured C was assessed by an 'approved healthcare professional' (I noted Mr Woolf's specific phrase). What happened in September 2019, when C was detained under s 2, should have happened in August 2020. Mr Parish had been deficient in carrying out his duties.
104. Mr Woolf said that although D2 accepted the existence of a duty of care towards C, any duty is hollow if, as D2 effectively seeks to contend, 'it is able to sidestep its own procedural obligations to ascertain whether the detainee is in fact at risk of harm'. PACE imposes specific obligations on the police which it must comply with to ascertain whether a detainee is a vulnerable person, then to ensure appropriate medical assessment and to carry out appropriate risk assessments during and prior to release from detention.
105. It is those procedural obligations that C contends D2 failed to comply with. D2 accepts that C should have been assessed as requiring an appropriate adult (ie, that there was reason to suspect he was a vulnerable person) and should have received appropriate clinical attention earlier in his period of custody when the concerns of his family in relation to his mental health should have been communicated to Detention Officer Gear. Those concerns were raised at the time of his initial arrest. From 3.29 on 12 August 2020, C was in fact determined by Sergeant Dejong as requiring an appropriate adult on account of his suspecting that C was vulnerable.
106. Having accepted or determined that there was reason to suspect that C was a vulnerable person, D2 was then under a duty to comply with the obligations set out in Code C, including ensuring C received appropriate clinical attention. Mr Woolf said D2 failed to ensure that C was seen by a healthcare professional. Mr Parish had been attending as a LDP.
107. As against D1, Mr Woolf submitted as follows.
108. First, there is no issue as to the existence of a duty of care by D1 towards C.
109. There was plainly a triable issue about what Mr Parish did and did not do and whether this was a breach of duty. He failed to ascertain C's full history and suicide risk (at least as shown by his notes on the Detention Log). Regarding talking to C's mother and GP, whilst C was precluded from making disclosure, he could have spoken to them to gather information. Mr Woolf said that at trial C would lead evidence that Mr

Parish had wrongly advised in relation to self-harm and had wrongly failed to ensure a further assessment by a mental health professional (as had happened in 2019). The records show C was seriously mentally ill at the time of his arrest in August 2020 and Mr Parish should have established this.

110. Similarly, in respect of Ms Hatfull, Mr Woolf said there was evidence she had negligently assessed C by recording he was not known to mental health services and that there was no relevant family history. He said that C would lead expert evidence that Ms Hatfull's performance of her duties had been sub-standard and that C's case should have been escalated.
111. In relation to causation arising from Ms Hatfull's alleged breaches, C's response is the same. If a proper assessment had been had carried out, steps would have been taken that would have safeguarded C and prevented the self-harm which occurred on 19 August 2020.

Legal principles relating to CPR r 3.4(2)(a) and CPR Part 24

112. The test to be applied on these applications are well established and were not in dispute.
113. Both strike out applications are brought pursuant to CPR r 3.4(2)(a), namely that the PoC disclose no reasonable grounds for bringing the claim.
114. CPRPD 3A, [1.2] gives examples of cases where the court may conclude that the particulars of claim fall within 3.4(2)(a), including instances where the claim sets out no facts indicating what the claim is about; the claims are incoherent and make no sense; or the claims contain a coherent set of facts but those facts, even if true, do not disclose any legally recognisable claim. For the reasons set out further below, none of those examples are capable of applying to the case C advances against both defendants.
115. The following further propositions also apply:
 - a. An application should not be granted unless the court is *certain* that the claim is bound to fail: see eg, *Hughes v Colin Richards* [2004] EWCA Civ 266, [22]:

“22. I start by considering what is the correct approach on a summary application of the nature of Mr Richards application at this early stage in the action when the pleadings show significant disputes of fact between the parties going to the existence and scope of the alleged duty of care. The correct approach is not in doubt: the court must be *certain* that the claim is bound to fail. Unless it is certain, the case is inappropriate for striking out (see *Barrett v Enfield London Borough Council* [2001] 2 AC 550 at p. 557 per Lord Browne-Wilkinson). Lord Browne-Wilkinson went on to add:

‘[I]n an area of the law which was uncertain and developing (such as the circumstances in which a

person can be held liable in negligence for the exercise of a statutory duty or power) it is not normally appropriate to strike out. In my judgment it is of great importance that such development should be on the basis of actual facts found at trial not on hypothetical facts assumed (possibly wrongly) to be true for the purpose of the strike out.”

- b. Where a statement of case is found to be defective, the court should consider whether that defect might be cured by amendments and, if it might be, the court should refrain from striking it out without first giving the party concerned an opportunity to amend: see eg, *Soo Kim v Young* [2011] EWHC 1781, [400].
116. In relation to the summary judgment applications, the principles were set out in *Easyair Limited v Opal Telecom Limited* [2009] EWHC 339 (Ch), [15]:
- a. The court must consider whether the claimant has a ‘realistic’ as opposed to a ‘fanciful’ prospect of success: *Swain v Hillman* [2001] 1 All ER 91, 92;
 - b. A ‘realistic’ claim is one that carries some degree of conviction. This means a claim that is more than merely arguable: *ED & F Man Liquid Products Limited v Patel* [2003] EWCA Civ 472 at [8]. In reaching its conclusion the court must not conduct a ‘mini-trial’: *Swain*, [95]
 - c. This, however, does not mean that the court must take at face value and without analysis everything that a claimant says in his statements before the court. In some cases it may be clear that there is no real substance in factual assertions made, particularly if contradicted by contemporaneous documents: *ED & F Man Liquid Products v Patel* at [10]
 - d. However, in reaching its conclusion the court must take into account not only the evidence actually placed before it on the application for summary judgment, but also the evidence that can reasonably be expected to be available at trial: *Royal Brompton Hospital NHS Trust v Hammond (No 5)* [2001] EWCA Civ 550, [19];
 - e. Although a case may turn out at trial not to be really complicated, it does not follow that it should be decided without the fuller investigation into the facts at trial than is possible or permissible on summary judgment. Thus the court should hesitate about making a final decision without a trial, even where there is no obvious conflict of fact at the time of the application, where reasonable grounds exist for believing that a fuller investigation into the facts of the case would add to or alter the evidence available to a trial judge and so affect the outcome of the case: *Doncaster Pharmaceuticals Group Ltd v Bolton Pharmaceutical Co 100 Ltd* [2007] FSR 63, [18];
 - f. On the other hand it is not uncommon for an application under CPR Part 24 to give rise to a short point of law or construction and, if the court is satisfied that it has before it all the evidence necessary for the proper determination of the question and that the parties have had an adequate opportunity to address it in argument, it should grasp the nettle and decide it. The reason is quite simple: if the respondent's case is

bad in law, he will in truth have no real prospect of succeeding on his claim or successfully defending the claim against him, as the case may be. Similarly, if the applicant's case is bad in law, the sooner that is determined, the better. If it is possible to show by evidence that although material in the form of documents or oral evidence that would put the documents in another light is not currently before the court, such material is likely to exist and can be expected to be available at trial, it would be wrong to give summary judgment because there would be a real, as opposed to a fanciful, prospect of success. However, it is not enough simply to argue that the case should be allowed to go to trial because 'something may turn up' which would have a bearing on the question of construction: *ICI Chemicals & Polymers Ltd v TTE Training Ltd* [2007] EWCA Civ 725, [14].

117. I also bear in mind the following matters.

118. Firstly, the points made in *Benyatov v Credit Suisse Securities (Europe) Ltd* [2020] EWHC 85 (QB), [60]:

- a. Striking out is a 'draconian step' which is only to be taken as a last resort: see *Biguzzi v Rank Leisure plc* [1999] 1 WLR 1926, 1933.
- b. In a strike-out application the proportionality of the sanction is very much in issue; see *Walsham Chalet Park Ltd v Tallington Lakes Ltd* [2014] EWCA Civ 1607.
- c. If the Court is able to say that a case is 'unwinnable' such that continuance of the proceedings is without any possible benefit to the respondent and would waste resources on both sides it may be struck out: see *Harris v Bolt Burdon* [2000] CP Rep 70, [27].
- d. an application to strike out the claim should not be granted where there are significant disputes of fact between the parties going to the existence and scope of an alleged duty of care unless the court is 'certain' (emphasis in original) that the claim is bound to fail: see *Hughes v Richards (t/a Colin Richards & Co)* [2004] EWCA Civ 266, [22].
- e. Where the legal viability of a cause of action is unclear (perhaps because the law is in a state of transition), or is in any way sensitive to the facts, an order to strike out should not be made': per Sir Thomas Bingham in *E (a minor) v Dorset County Council* [1994] 4 All ER 640f, [1995] 2 AC 633B.
- f. It is not appropriate to strike out a claim in an area of developing jurisprudence, since, in such areas, decisions as to novel points of law should be based on actual findings of fact: see *Farah v British Airways* [1999] All ER (D) 1381, (2000) Times, 26 January, CA at [42] referring to *Barrett v Enfield London Borough Council* [2001] 2 AC 550 and *X (minors) v Bedfordshire County Council* [1995] 2 AC 633.
- g. A statement of case is not suitable for striking out if it raises a serious live issue of fact which can only be properly determined by hearing oral evidence: see *Bridgeman v McAlpine-Brown* (19 January 2000, unreported),[24].

119. Second, as to the possibility of future evidence, in *King v Stiefel* [2021] EWHC 1045 (Comm) Cockerill J said:

“21. The authorities therefore make clear that in the context of summary judgment the court is by no means barred from evaluating the evidence, and concluding that on the evidence there is no real (as opposed to fanciful) prospect of success. It will of course be cautious in doing so. It will bear in mind the clarity of the evidence available and the potential for other evidence to be available at trial which is likely to bear on the issues. It will avoid conducting a mini-trial. But there will be cases where the Court will be entitled to draw a line and say that - even bearing well in mind all of those points - it would be contrary to principle for a case to proceed to trial.

22. So, when faced with a summary judgment application it is not enough to say, with Mr Micawber, that ‘something may turn up’.”

120. Hence, a respondent to a summary judgment application who claims that further evidence will be available at trial must substantiate that claim: *Korea National Insurance Corp v Allianz Global Corporate & Specialty AG (formerly Allianz Marine & Aviation Versicherung AG)* [2007] EWCA Civ 1066, [13]-[14]:

“13. In seeking to overturn the judge's decision Mr. Pollock Q.C. for Allianz has drawn our attention to some of the many cases in which this court and others have warned against the dangers of disposing summarily of arguments that appear at first sight to be implausible or depend on establishing facts which, at the time of the application, seem very unlikely to have occurred. These warnings must be taken seriously because experience tells one that the picture that emerges at trial, when all the evidence has been examined, often differs markedly from that which presents itself at an earlier stage. For that reason the court on an application for summary judgment will normally accept the parties' evidence at face value, as the judge did in this case, and will refuse to be drawn into an attempt to resolve factual disputes of any kind. However, a party cannot complain if, accepting his evidence at face value, the court adopts a rigorous approach when considering what, if anything, that evidence amounts to.

14. In the present case Allianz criticised the judge for having failed to make allowance in its favour for the likelihood that additional evidence relating to various aspects of this defence would be available at trial to cast a more benevolent light on events, but in my view that

criticism is unfounded. It is incumbent on a party responding to an application for summary judgment to put forward sufficient evidence to satisfy the court that it has a real prospect of succeeding at trial. If it wishes to rely on the likelihood that further evidence will be available at that stage, it must substantiate that assertion by describing, at least in general terms, the nature of the evidence, its source and its relevance to the issues before the court. The court may then be able to see that there is some substance in the point and that the party in question is not simply playing for time in the hope that something will turn up. It is not sufficient, therefore, for a party simply to say that further evidence will or may be available, especially when that evidence is, or can be expected to be, already within its possession, as is the case here. Allianz was quite entitled, if it so chose, to confine its evidence to the factual allegations in the defence, but having done so, and having failed to give any indication of what other evidence can be expected to be available at trial, it cannot complain that the court has not speculated about whether there might be any such evidence, and if so what its nature might be.”

121. Third, in some cases the disputed issues are such that the outcome largely depends upon the expert evidence relied on by each side. In such cases, for example clinical negligence cases, an application for summary judgment will usually be inappropriate, unless it is made after the exchange of the experts’ reports and, in most cases, after the experts have discussed the case and produced a joint statement. That said, there is no absolute rule. In *Hewes*, which I referred to earlier, Foskett J said at [45]:

“45. I have been told that there has been no reported decision of a successful summary judgment application in a clinical negligence case. As a matter of principle there is no reason why clinical negligence cases are any different from any other case and an obviously weak case on liability or causation is vulnerable to such an application. That said, there will be few cases, in my view, where such an application could ordinarily be contemplated before the relevant experts’ reports have been exchanged and, in most cases, until after the experts have discussed the case and produced a joint statement. Experts do from time to time change their views in the light of discussions with their counterparts and, whilst it is not to be encouraged and is ordinarily unsuccessful, there are occasions when a party will make a credible application to substitute another expert at some stage. This means that the task of considering, on a summary judgment application, evidence “which can reasonably be expected to be available at trial and the lack of it” (see *Royal Brompton Hospital NHS Trust v Hammond* [2001] EWCA Civ 550 at [19] and *Tesco Stores Ltd v Mastercard Incorporated* [2015]

EWHC 1145 (Ch) at [9]-[10]) is one that needs to be undertaken with caution.”

122. Fourth, a judge is not bound to accept expert evidence which cannot be logically supported, although such cases might be rare: *Bolitho*, 243C-E:

“I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes D clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed.”

Discussion

123. Again, I will consider the applications in the order I was addressed. As was rightly submitted, D1's and D2's applications do not stand or fall together. I have considered them separately, although there is substantial overlap between them.

D2's applications

124. Paragraph 9 of D2's Skeleton Argument puts his case thus:

“In this case (while not specifically pleaded) the Second Defendant accepts that there is a duty to take reasonable care of a person detained in a police station but does not accept the extent of the duty contended for or that there was a breach of that duty that caused the damage sustained by the Claimant.”

125. Hence, D2 denies: (a) that a duty of care existed in relation to the particular failures complained of; alternatively (b) that there was a breach of duty; and (c) any breach was causative of C's injuries.

126. The police's general duty of care was examined at length by the Supreme Court in *Robinson v Chief Constable of West Yorkshire Police* [2018] AC 736. The essential question was whether the Chief Constable was liable in negligence for injuries caused by his officers to a passer-by in the course of a struggle when they were attempting to carry out an arrest in a busy street. The Court undertook a thorough review of the law relating to duty of care and how the decisions in *Anns v Merton London Borough Council* [1978] AC 728, *Hill v Chief Constable of West Yorkshire* [1989] AC 53,

Caparo Industries plc v Dickman [1990] 2 AC 605, and others, were properly to be understood.

127. For present purposes, the following points from Lord Reed’s judgment are relevant.
128. Firstly, the police generally owe a duty of care to others in accordance with the ordinary principles of the law of negligence unless statute or the common law provides otherwise, and there is no general rule that they are not under such a duty of care when discharging their functions of preventing and investigating crime. That general duty is a duty to take reasonable care to avoid acts which the defendant can reasonably foresee would be likely to injure those persons who the defendant ought reasonably to have in their contemplation. Or, more straightforwardly, as Lord Reed said at [48], the police owe the general common law of care ‘to avoid causing reasonably foreseeable injury to persons and reasonably foreseeable damage to property.’
129. Second, public authorities such as the police, like private individuals and bodies, are generally under no duty to prevent the occurrence of harm: *Robinson*, [34]. As Lord Toulson stated in *Michael v Chief Constable of South Wales Police (Refuge intervening)* [2015] AC 1732, [97], ‘the common law does not generally impose liability for pure omissions’. This is sometimes known as the ‘omissions principle’.
130. However, there may be circumstances where there will be liability in respect of omissions, such as where the defendant has assumed responsibility for the care of another. The paradigm situation in relation to the police is where they have detained a person in custody.
131. The police owe a detainee a duty to take reasonable care for their safety, and that duty extends to both acts and omissions: see eg *Reeves*, where a detainee had hanged himself from the flap in his cell door which had been negligently left open in breach of policy; the breach of duty (an omission) was accepted by the Commissioner. Lord Hope said at p380 on the duty of care:

“The duty of those who are entrusted with [a prisoner's] custody is to take reasonable care for his safety while he remains in their hands. If it is known that he may engage in self-mutilation or suicide while he is in their custody, their duty is to take reasonable care to prevent him from engaging in these acts so that he remain free from harm until he is set at liberty. This duty is owed to the prisoner if there is that risk, irrespective of whether he is mentally disordered or of sound mind. It arises simply from the fact that he is being detained by them in custody and is known to be at risk of engaging in self-mutilation or of committing suicide.”

132. In *Kirkham*, Farquharson LJ said at p284:

“... The position must, in my judgment, be different when one person is in the lawful custody of another, whether that be voluntarily, as is usually the case in a hospital or involuntarily, as when a person is detained by the police or

by prison authorities. In such circumstances, there is a duty upon the person having custody of another to take all reasonable steps to avoid acts or omissions which he could reasonably foresee would be likely to harm the person for whom he is responsible.”

133. This general duty of care was accepted by Ms Studd on behalf of D2. Where D2 parts company with C is whether the duty extended to the omissions pleaded in [35] of the PoC. As I have set out, she submitted there is no arguable cases that they did, and hence that D2’s case even as pleaded is bound to fail.
134. The gist of the breaches of duty alleged against D2 are that he was initially wrongly assessed by the Detention Officer on arrival as not having mental health difficulties and so as not being vulnerable for the purposes of the Code C of PACE; and that the police did not ensure that he was properly assessed by an a healthcare professional, and then completed an inaccurate pre-release risk assessment.
135. At this point I need to consider whether: (a) D2’s case is properly analysed as being that he did not, on the pleaded facts, owe C a duty of care: or (b) whether it is a case where there was a duty of care, but on the pleaded facts there was no arguable breach of that duty.
136. In his case note on the decision of the Court of Appeal in *Darnley v Croydon Health Services NHS Trust* [2017] EWCA Civ 151, at [2017] CLJ 480, Professor James Goudcamp of the University of Oxford said that the case was:

“...an important development in this regard in that it contributes significantly to the erosion of the customary divide between the duty of care and breach elements of the action in negligence. The consequence of that erosion is that cases that would previously have been understood as being breach cases are increasingly being treated as – and only as – duty cases. In short, contrary to the conventional structure of the tort of negligence, the breach element of the action is gradually disappearing.”

137. The facts of *Darnley* were that a man who had been attacked and suffered a head injury attended hospital and was told, wrongly, by a receptionist that he would have to wait four to five hours before being seen. He left the hospital without being seen, and as a consequence suffered permanent brain damage. If he had been dealt with as he should have been under established hospital procedures, he would have been triaged within thirty minutes and his brain injury would almost certainly have been avoided. The Court of Appeal by a majority dismissed the claimant’s case on the basis the hospital did not owe him a duty of care.
138. Professor Goudcamp’s view, however, which was expressly endorsed by the Supreme Court in allowing the claimant’s appeal (at [2019] AC 831, [23]), was that the case was about whether there had been a breach of duty by the hospital, and not whether a duty of care had been owed to the claimant by the hospital. He said at pp481-2:

“The claimant commenced proceedings for damages and the defendant NHS trust admitted that, had the claimant been treated promptly, he would have made a full recovery. Expert witnesses were unanimous in their opinion that the claimant should have been seen by the triage nurse within 30 minutes of arrival at the hospital. However, the trial judge held, amongst other things, that it was not fair, just and reasonable to impose a duty of care on the defendant's reception staff to give accurate information about waiting times, and the claimant's action consequently failed ([2015] EWHC 2301 (QB)). An appeal to the Court of Appeal was dismissed by a majority (Jackson and Sales LJJ; McCombe LJ dissenting). The majority reasons in *Darnley* similarly concentrated whether the defendant owed the claimant a duty. That focus was surprising given that it is, of course, trite law that hospitals owe a duty to their patients. The claimant was certainly a patient (or analogous to a patient) on account of his having presented himself at the hospital's accident and emergency department, and no member of the Court of Appeal seemed to suggest otherwise, with all of the Lords Justices referring repeatedly to the claimant as a ‘patient’. Accordingly, on traditional principles, *Darnley* is not, in fact, a duty of care case at all. Rather, properly understood, the issue was whether the defendant had breached its duty in giving, by its receptionist, inaccurate information to the claimant.

The mode of analysis in *Darnley* is far from atypical. Judges, by over-specifying the content of the duty of care element, routinely treat breach cases as though they were duty cases (another recent illustration is *Southern v Adventure Forest Limited* [2016] EWCA Civ 1178, at [31], in which the court held that an occupier did not owe an invitee a duty of care in respect of a particular danger on the premises). Judges who proceed in this way typically utter formulae such as: ‘no duty of care was owed by the defendant in the present case to do [X] because the reasonable person in the defendant's position would not have done [X]. However, the structure of that phrase reveals immediately that the duty of care element is not in play at all. The very fact that the court is discussing what the reasonable person in the defendant's position would have done indicates that the dispute is actually about the breach element, that being the only element of the action in negligence that is concerned with the satisfactoriness of the defendant's conduct ...

Pursuant to established doctrine, *Darnley* should have been analysed as follows. Any suggestion that the

defendant did not owe the claimant a duty of care should have been given short shrift. That is because *Darnley* was completely lacking in features that could possibly be thought to have given rise to any duty issue. The parties were within an established duty category. The damage complained of was personal injury rather than (for example) pure mental or economic harm. Neither was there any suggestion that *Darnley* involved a mere omission. It follows, and follows straightforwardly, that a duty of care was owed to the claimant. The only question in *Darnley*, relevantly, was whether the defendant breached its duty.”

139. In his judgment in the Supreme Court, Lord Lloyd-Jones said at [14], [16], [21], [23]:

“14. I consider that the approach of the majority in the Court of Appeal to the issue of duty of care is flawed in a number of respects.

...

16. In the present case Jackson LJ observed (at para 53) that to hold the defendant responsible would create ‘a new head of liability for NHS health trusts’. To my mind, however, the present case falls squarely within an established category of duty of care. It has long been established that such a duty is owed by those who provide and run a casualty department to persons presenting themselves complaining of illness or injury and before they are treated or received into care in the hospital’s wards. The duty is one to take reasonable care not to cause physical injury to the patient: *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 428, per Nield J, at pp 435–436. In the present case, as soon as the claimant had attended at the defendant’s A & E department seeking medical attention for the injury he had sustained, had provided the information requested by the receptionist and had been ‘booked in’, he was accepted into the system and entered into a relationship with the defendant of patient and health care provider. The damage complained of is physical injury and not economic loss. This is a distinct and recognisable situation in which the law imposes a duty of care. Moreover, the scope of the duty to take reasonable care not to act in such a way as foreseeably to cause such a patient to sustain physical injury clearly extends to a duty to take reasonable care not to provide misleading information which may foreseeably cause physical injury

...

21. Thirdly, I consider that the judgments of the majority in the Court of Appeal elide issues of the existence of a duty of care and negligent breach of duty. They place emphasis on what a reasonable person would have done 841and could reasonably be expected to have done in the context of a busy A & E department. Thus Jackson LJ draws attention to the difficult conditions in which staff at such departments often have to work, observing, at para 54, that A & E department waiting areas are not always havens of tranquillity. Similarly, Sales LJ considers, at paras 84–87, that if there is a duty to provide “precise and accurate information” about the length of time before a patient might be seen by a triage nurse, it is difficult to see why it does not extend to an obligation to correct such information as changing pressures on resources arise. He observes, at paras 85, 87, that it would not be fair, just or reasonable to impose “a duty of fine-grained perfection” regarding the information provided and that “it is not as a matter of legal duty incumbent on a receptionist and the employing NHS trust to provide minute-perfect or hour-perfect information about how long the wait might be”. These observations seem to me to be directed at false targets; it is not suggested that receptionists in an A & E department should act in this way. The question under consideration is whether the defendant owes a duty to take reasonable care when providing, by its receptionists, information as to the period of time within which medical attention is likely to be available. More fundamentally, however, these observations are really concerned not with the existence of a duty of care but with the question whether there has been a negligent breach of duty as a result of a failure to meet the standard reasonably expected.

..

23. Finally in this regard, I should record that in considering the issue of duty of care I have been greatly assisted by a case note on the decision of the Court of Appeal in the present case by Professor James Goudkamp [2017] CLJ 480. He considers that the parties were within an established duty category and that the only question, relevantly, was whether the defendant 842breached that duty. He observes that discussion as to what the reasonable person would have done in the circumstances in question indicates that the dispute is about the breach element, that being the only element of the cause of action in negligence that is concerned with the satisfactoriness of the defendant’s conduct. He concludes, at p 482:

‘Accordingly, on traditional principles, *Darnley* is not, in fact, a duty of care case at all. Rather, properly understood, the issue was whether the defendant had breached its duty in giving, by its receptionist, inaccurate information to the claimant.’

I agree with his analysis. It is to that question of negligent breach of duty that I now turn.”

140. He went on to find that the Trust had breached its duty when the receptionist had provided wrong advice to the claimant, saying at [27]:

“27. ... The trial judge made the critical finding that it was reasonably foreseeable that a person who believes that it may be four or five hours before he will be seen by a doctor may decide to leave. In the light of that finding I have no doubt that the provision of such misleading information by a receptionist as to the time within which medical assistance might be available was negligent.”

141. Turning to the case before me, it is plain from the authorities that the police owed a duty to C in respect of acts and omissions whilst he was in their custody. In other words, as in *Darnley*, the parties were ‘within an established duty category’. Hence, in my judgment, the present case is properly to be analysed in the same way, namely, whether there were arguable breaches of that duty by the police. The question is whether it is sufficiently arguable that the police failed to take reasonable care to avoid acts or omissions which it was reasonably foreseeable would lead C to commit serious self-harm.
142. For present purposes, the steps which the police needed to take vis-à-vis C in order to fulfil their duty to take reasonable care whilst in their custody were those to be found in Code C and other relevant professional guidance, such as that issued by the College of Policing (see Claimant’s Skeleton Argument, [40]). I did not understand this to be an issue between the parties.
143. I am prepared to accept for the purposes of these applications that the initial assessment by Detention Officer Grear following C’s arrest on 11 August 2020, namely that C did not require medical attention and did not require an appropriate adult, was wrong and a breach of duty, given C’s mental health history as reported to the police. Hence, to that extent, D2 breached his duty of care to C.
144. However, this breach plainly had no causative effect in relation to C’s injury because it was remedied by: (a) the re-assessment by Sergeant Dejong at 3.29 the following morning which re-classified C as vulnerable; (b) the attendance of Mr Parish on 12 August 2020, who twice attempted to engage with C; (c) the subsequent attendance of C’s mother in the police station and in interview as his appropriate adult; and (d) C having legal representation at interview. I do not read the PoC as saying Mr Grear’s failure was causative of what occurred on 19 August 2020, but to the extent that it is, I reject the suggestion as unarguable.

145. Having determined that there was reason to suspect that C was a vulnerable person (as defined in [1.13(d)] of Code C and the Guidance Notes at 1G), D2's officers were then required to fulfil the duties set out in Code C, including (but not limited to) making sure C received 'appropriate clinical attention' as soon as reasonably practicable ([9.5(c)]), even if he did not ask for it, because he appeared to be suffering from a mental disorder.
146. The focus therefore has to be on Mr Parish, and D2's alleged failures consequent upon his interactions with C. To re-iterate, [35(ii) and (iii)] of the PoC aver against D2:
- “(ii) Having determined at 3.29 on 12 August 2020 that the Claimant required an appropriate adult, failed to ensure that the Claimant underwent an appropriate and effective mental health assessment by a Healthcare Professional to determine if he was fit to be interviewed in accordance with Code C of the Police and Criminal Evidence Act 1984 ('PACE') and the College of Policing Authorised Professional Practice.
- (iii) Upon Mr Parish of the CJLDS failing or being unable to undertake any mental health assessment, failed in any event to ensure that the Claimant underwent an appropriate and effective psychiatric assessment by a Healthcare Professional in accordance with the requirements of Code C of PACE.”
147. There is, at this point, a need to be precise. With respect to Mr Woolf, in his submissions he used the phrases, 'appropriate clinical attention', 'appropriate healthcare professional', 'mental health assessment' and 'Mental Health Act assessment' rather interchangeably and imprecisely.
148. As I set out earlier, D2's duty under [9.5] was to ensure that C, as a detainee who appeared to be suffering from a mental disorder, received 'appropriate clinical attention'. The custody officer's duties under [3.5] included, in response to any specific risk assessment, 'calling an appropriate healthcare professional'.
149. In my judgment there can be no argument but that the police fulfilled their duty of care by ensuring that C received 'appropriate clinical attention' as Code C required. My reasons are as follows.
150. Firstly, beginning with who Mr Parish is, as a community psychiatric nurse, he is a 'healthcare professional' as defined in Code C, Note 9A. True it is that he was attending as an LDP, but that did not mean he was not a healthcare professional for the purposes of Code C. It follows that I do not agree with the points made by Mr Woolf in his Skeleton Argument, [41], about the different roles and responsibilities of an LDP as compared with a healthcare professional. Mr Parish was a healthcare professional whose role including screening C and then referring him for further assessment if necessary. That is what happened in September 2019, and I will say more in a moment.

151. Second, it was not for the police to determine what sort of clinical attention was to be provided – eg, a Approved Mental Health Professional, or a registered practitioner approved under s 12 of the MHA 1983, as opposed to a mental health nurse like Mr Parish. Their judgement that Mr Parish, as a qualified mental health nurse employed by D1 in its CJLDS, was able to provide *appropriate* clinical attention, was reasonable.
152. Third, Mr Parish attended *inter alia* to assess C’s mental health needs. As I set out earlier, as an SLDP one of Mr Parish’s tasks was to carry out a screening of C *in order to determine whether a further assessment of his mental health was required*. Ms Studd showed me the Liaison and Diversion Standard Service Specification 2019, which outlines the role of an LDP. Paragraph 2.5 provides:

“Where an individual is referred to the service they must be offered a screening appointment to be conducted by an L&D practitioner. The service will screen for a wide range of conditions and vulnerabilities using a trauma informed approach ...

...

Individuals will be offered a further assessment linked to needs identified through the screening process.

The service will liaise with any professionals working with the individual to discuss and agree onward referrals.”

153. Paragraph 2.8.3 in the contract states:

“2.8.3 Exclusion criteria

The following functions will not be pursued as part of the L&D service:

- removal and detention of an individual in accordance with section 136 of the Mental Health Act 1983
- street triage services
- fitness to detain, fitness to interview and pre-release risk assessments
- mental Health Act assessments
- custodial in-reach services or post release services.

However, it will be important for providers of L&D services to build interfaces with providers of the above functions. This service will also address the sharing of relevant flows of information with those providers, to ensure that any relevant diagnoses are made known for the purposes of access to appropriate health and social care services.”

154. Mr Parish was well aware of the option of referral, not least because that is what happened in September 2019. He recorded it in the Detention Log (emphasis added):

“In September 2019 he was in A+E seeking psychiatric assessment amid concerns of paranoia, delusions and low mood. He left the department after waiting for 8+ hrs and not being seen. At home there was an altercation over the preparation of a sandwich leading him to go to his grandfathers where he ended up assaulting him and causing criminal damage. *In custody he saw my CJLDS colleague who referred him for a mental health act assessment. He was detained under section two and admitted to hospital.* He was felt to be exhibiting symptoms of a drug induced psychosis and was discharged three days later. He was referred to community mental health services but was not felt to meet the criteria for any service so was subsequently discharged.”

155. Fourth, there is nothing on the face of Code C to indicate that the police were under the sort of ‘review duty’ contended for by C. Paragraphs [9.13]-[9.14] provide:

“9.13 Whenever the appropriate healthcare professional is called in accordance with this section to examine or treat a detainee, the custody officer shall ask for their opinion about:

- any risks or problems which police need to take into account when making decisions about the detainee’s continued detention;
- when to carry out an interview if applicable; and
- the need for safeguards.

9.14 When clinical directions are given by the appropriate healthcare professional, whether orally or in writing, and the custody officer has any doubts or is in any way uncertain about any aspect of the directions, the custody officer shall ask for clarification. It is particularly important that directions concerning the frequency of visits are clear, precise and capable of being implemented. See Note 9F.”

156. Note 9F provides:

“The custody officer should always seek to clarify directions that the detainee requires constant observation or supervision and should ask the appropriate healthcare professional to explain precisely what action needs to be taken to implement such directions.”

157. These provisions, it seems to me, are all predicated on it being reasonable for the police to rely upon the opinion and advice of the Code C healthcare professional who has been requested to attend upon a detainee with mental health issues.
158. There is also nothing in the College of Policing's Authorised Professional Practice, cited by C, which takes his case any further. This simply says:
- “Officers should seek advice from an appropriate HCP [health care professional] if they have concern that a detainee has an injury, medical condition or a mental illness, appears to be experiencing mental ill health or otherwise requires medical attention. This does not apply to minor injuries or ailments, but officers should still note those in the custody record. If unsure of the nature of a condition, officers should call an HCP. See PACE Code C paragraph 9.5 and Notes for Guidance, Note 9C.”
159. In other words, the police were not required, as part of their Code C duties, to conduct some sort of ‘quality audit’ of what Mr Parish did. They were reasonably entitled to assume that Mr Parish had carried out his duties properly, and that if he thought that a mental health assessment, or an assessment under MHA 1983 by a s 12 practitioner (the two are not the same), needed to be carried out, or that something else needed to be done, that he would say so.
160. As I said earlier, Ms Studd accepted that there could be an extreme case where the mere attendance of a healthcare professional at the request of the police would not be sufficient to fulfil the police's Code C duty. One example that springs to mind is if the police were to become aware that the healthcare professional had not attempted to carry out any sort of screening at all. But there is nothing pleaded in the PoC, and nothing else on the facts, which could even arguably be said to have triggered such a duty in this case. Mr Parish tried twice to carry out an assessment of C in accordance with his role, but C refused to cooperate and it is not said that C lacked capacity.
161. I therefore conclude that C's case on breach as pleaded in [35(ii) and (iii)] fails. C has no realistic prospects of succeeding in showing D2 breached his duty of care as alleged. The police fulfilled their duty of care by summoning Mr Parish, and were entitled to rely upon his opinion and conclusions. Whether these were right or wrong was not for the police to say because they were not qualified to do so.
162. The position on 12 August 2020 finds a parallel in what happened on 7 September 2019 when C was arrested. I have already alluded to this. The summary of the records in the bundle show that on that occasion C was first seen by D1's CJLDS (as on 12 August 2020). He was then assessed by an Approved Mental Health Practitioner. (This is a statutory role created by the Mental Health Act 2007, s 18. Such persons need not be doctors). That person recommended C's detention under s 2 of the MHA 1983. C was then duly detained following assessment by two s 12 approved practitioners.

163. Mr Woolf said that on 12 August 2020 C should also have been detained, but as Ms Studd said, if that did not happen, responsibility lay (if anywhere) at D1's door, and not D2's, whose officers did all that they needed to do under Code C. I agree.
164. I turn to the other main allegation of breach against D2. Paragraph 35(iv) alleges that D2 failed to carry out a competent pre-release risk assessment. I do not see what causative potency that could have had in respect of C's injuries, which it is said would have been avoided had he been sectioned as he says he should have been. Causation is not pleaded in relation to this alleged breach. It is not explained how the risk assessment would have made a difference to the outcome, as [37] and [38] relate to the failure to provide the C with an appropriate and effective mental health assessment.
165. Furthermore, as Ms Studd said, any causative effect of the risk assessment disappeared when C dealt with D1's mental health services on 15 August 2020 and thereafter, and was re-assessed.
166. It follows that C's case against D2 fails. C has no realistic prospects of success and I therefore grant summary judgment in D2's favour pursuant to CPR r 24.3(a). For the same reasons, C's claim is also struck out under CPR r 3.4(2)(a) as having no reasonable prospects of success. (For the avoidance of doubt, as the notes to the White Book 2024, [3.4.2] make clear, there is no exact dividing line between the power to grant summary judgment under CPR r 24.3(a) and the power to strike out under CPR r 3.4(2)(a); and see also [3.4.21]: 'Many cases fall within both r.3.4 and Pt 24 and it is often appropriate for a party to combine a striking out application with an application for summary judgment. Indeed, the court may treat an application under r.3.4(2)(a) as if it was an application under Pt 24'.

D1's applications

167. It is not in dispute that D1 owed a duty to take reasonable care in relation to C's mental health and to avoid acts or omissions which might foreseeably cause injury to C.
168. C's allegations of breach of duty by Mr Parish are in [34 (i)] of the PoC. In summary, it is alleged that Mr Parish failed to pay any sufficient regard to the risk of self-harm save for the prior detention under s 136 of the MHA 1983. It is further alleged that Mr Parish wrongly determined that he was unable to speak with C's mother or write to his GP and that Mr Parish failed to carry out any meaningful assessment or screening process and failed to ensure that C underwent a competent and effective psychiatric assessment either voluntarily or under the MHA 1983.
169. Taking each of these in turn, my conclusions are as follows.
170. I think there is merit in the criticism of Mr Parish that he did not fully ascertain C's history of threatened self-harm and so was not fully sighted upon it when he came to decide how to deal with C on 12 August 2020. There was more to C's threatened risk of self-harm than just the incident in January 2019 which Mr Parish recorded. The summary of C's medical records in the bundle reveal the following (some of which I was not referred to during the hearing, but there is no issue about their accuracy.)

171. Firstly, after the bridge incident in January 2019, his mother told Ms Quinn that she was ‘very worried about him and told me that he has threatened suicide previously but not acted.’

172. On 30 August 2019 his GP notes recorded:

“mood low mood for over 5 years, ‘he’s not felt right’, poor sleep and passive suicidal thoughts last year but tells me he is no longer having it.”

173. On 7 September 2019 the notes record: ‘... one of the nurses in A&E referred Tyler liaison assessment. Reported that Tyler went missing, found low and suicidal.’ Also on 7 September 2019, ‘... Father reports history of suicide attempts.’

174. Further, D1’s notes on that day recorded, ‘...has come into custody claiming he is Jesus and last night ran out of the house stating he wanted to kill himself ...’. Also on 7 September 2019 there was this entry following his mental assessment by the Approved Mental Health Practitioner:

“March 2019 seen by CJLDS ... No evidence of mental disorder (He refused assessment – KR) ...December 2018 His mother reported that he first reported hearing voices. According to his mother he drove off with a hose pipe threatening suicide. His father found him and stopped him.”

175. Further on 7 September 2019: ‘There are reports that he has expressed suicidal ideations which he denies.’

176. On 8 September 2019:

“When assessed he was described as having grandiose delusions believing he had been reincarnated into Jesus and had also ran out of the house the night before saying he wanted to kill himself ...

Risk of harm to self and others on discharge were low however risks are largely impacted on by illicit substance misuse and Tyler is aware of this and need to desist from illicit substance misuse. He has capacity to make decisions around his drug misuse

Diagnosis Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances / Psychotic disorder”

177. I consider these entries paint a picture of C’s risk of suicide/self-harm having been a feature of the concerns about his mental health from at least early 2019 onwards, and there had not just been a single episode, as Mr Parish noted.

178. The records I have referred to were, or should have been, available to Mr Parish when he came to try and assess C on 12 August 2020.
179. I next turn to the complaint that Mr Parish wrongly determined that he was unable to speak with C's mother, or write to his GP, to find out more information about his mental health because of C's lack of consent. The note made by Mr Parish on 12 August 2020 was, 'I am unable to speak with his mother or write to his GP without his consent, which he is clearly not going to give to me.'
180. Initially, I was sceptical about this argument, and ventured during the hearing the possible view that whilst C's lack of consent might not have absolutely prevented Mr Parish from speaking to C's mother or GP, the reality is that any conversation would have been a short one of little value. I noted the absence of any clear pleading about what such a conversation could have revealed which would have been of assistance.
181. Having reflected, however, I consider that there is force in Mr Woolf's submission that if he had spoken to C's mother or GP, Mr Parish could have asked – without breaching confidentiality - about what they had witnessed about C's state of mind over the previous two years and whether there had been in their mind concerns about his risk of self-harm and, if so, why.
182. To illustrate this, as well as the matters already set out which C's mother could have relayed, there is this entry from around 7 July 2020:

“According to history subsequently given by the Claimant's mother, the Claimant gradually deteriorated over time and demonstrated a number of bizarre behaviours, including talking to voices in an empty bathroom, screaming about people banging doors at home, talking about being God and Jesus and healing the world and thinking that people were coming to kill him. He developed a hatred of the colour red and anyone who wears it and has been witnessed to write pages of “gobbledgook” and fixate on seemingly random themes.”

183. Further, on 11 August 2020 PC Stephens made this entry at 20.15:

“During the time at the address, the family have strongly and repeatedly stated that this is a MH episode. I have raised their concerns with Medway Custody and asked for them to update the custody record and that he is assessed by the CPN.

The family have stated that they have known this incident is coming for a few days. Yesterday Tyler spent several hours sat in front of a mirror growling at himself. He also continually states that he is Jesus and the messiah. Approximately a year ago Tyler became a HR MISPER. He was later found by the helicopter on a bridge over the A2 threatening to kill himself. He has made repeated threats of suicide and his family are concerned they are

seeing the same signs that led up this incident last year. There is also a family history of paranoid schizophrenia. Tyler's uncle and Marcus' brother suffered from the same condition and hung himself some years ago. Therefore the family are very passionate about this subject and are adamant that they want him sectioned.

They have only plastic cups in the house and the knives have been hidden in an alleyway next to the house because they live in fear as a result of Tyler's behaviour.”

184. It therefore seems to me that it is at the very least arguable that Mr Parish could have gathered information from C's mother and GP, and that he was in breach of duty towards C in not doing so. Even to my non-expert eye, had he done so then quite a lot of relevant evidence might have been provided which could have affected Mr Parish's assessment. It was no small matter for C's family to have expressed themselves to PC Stephens as they did, including that they thought C needed to be sectioned. Whether Mr Parish was correct in his apparent belief that he was bound by C's lack of consent not to have any contact with them *at all*, seems to me to be a proper matter for expert evidence having regard to relevant professional practice and guidance.
185. These two matters, namely Mr Parish's failure to ascertain C's full self-harm history, and his failure to speak to C's mother or GP. are really two components of the same alleged breach, namely to ascertain a proper and accurate picture about C's mental health history for the purposes of assessing/screening him.
186. I therefore consider that C has a realistic prospect of showing that D1, through Mr Parish, failed properly to ascertain C's mental health history (at least as evidenced by the notes he made in the Detention Log) on 12 August 2020 and so failed to carry out a proper screening assessment.
187. The question, then, is what flows from this arguable breach. I acknowledge the strength of the points made by Mr Trusted that: C had capacity; he repeatedly refused to engage with Mr Parish, which he was entitled to do; and that there is little to show that he was psychotic around 12 August 2020, or during the subsequent week when he dealt with Ms Hatfull, or when was assessed in Kings College Hospital in early September 2020 following his accident, and hence there was no basis for him being detained on any view.
188. However, the conditions for compulsory detention under the MHA 1983 for either assessment or treatment are not limited to cases of psychosis. Section 2(2) (admission for assessment) provides:
 - “(2) An application for admission for assessment may be made in respect of a patient on the grounds that -
 - (a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and

(b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.”

189. Having capacity is also not a bar to being compulsorily detained. In the notes for 8 September 2019 following C’s detention there was this from the duty psychiatrist:

“...Capacity Fully capacitous. Diagnosis Drug induced psychosis. Plan he needs antipsychotic medication. No indication for his prescribed citalopram. Not ready for section 17 leave yet prn medication.”

190. I also cannot ignore the fact that C’s detention in September 2019 took place despite C denying that he had ‘any problems and reported that he actually feels quite clear in his head’.

191. It therefore seems to me that there is a triable issue as to whether a properly conducted screening by Mr Parish would have led to a further mental health assessment – or assessments - and compulsory detention in light of C’s presentation, his extensive mental health history, and his MHA 1983 detention a year earlier. Whilst, as Mr Trusted said, it was not possible for Mr Parish himself to have conducted an assessment given C’s refusals, there were other options open to him by way of referring the case upward to others who could have assessed C.

192. Turning to the alleged breaches by Ms Hatfull, the gist of these is that she failed to gather a proper history and failed to carry out a proper screening, despite apparent evidence of psychosis being relayed to her colleague Ms Pinduke, and wrongly discharged C. This is evidenced by her erroneous completion of the screening form.

193. I also consider that there is a triable issue that there were also breaches of duty by Ms Hatfull. As pleaded in [16] of the PoC, she was arguably wrong to state on the form she completed on 15 August 2020 that C was not known to local mental health services or other agencies; that there was no history of mental illness in the family; and that C had never attempted suicide. As to the last, whether what happened in January 2019 was properly an ‘attempt’ seems less important than the history of suicide threats by C which I outlined earlier. As to this, the box ‘Client Risks (protective factors, self-harm, risk to others, risk from others, etc)’ was left blank and no reference made to these earlier suicide concerns. Also, given that C had been arrested in the days before for assaulting his father and sister (and was then on bail), and had assaulted his grandfather the previous year, the fact no reference was made to this (as ‘risk to others’) is surprising. Whilst not said to be a breach of duty, this omission is perhaps indicative of the incomplete way in which Ms Hatfull conducted her assessment of C.

194. Again, I understand D1’s case that circumstances were difficult in August 2020 because of COVID; that days earlier he had been fit for a PACE interview; and that he had capacity on 15 August 2020; that there is no evidence around that date he was at imminent risk of self-harm, or suffering from a mental illness, such that an urgent MHA 1983 assessment was then required.

195. However, all these matters seem to me to relate to triable issues. As I have already said, lack of capacity is not of itself a bar to compulsory detention. The risk of suicide was

arguably not properly assessed by Ms Hatfull. And whether C was suffering from a mental illness requiring an urgent MHA 1983 assessment on 15 August 2020 is a matter of expert evidence. It is relevant that just four days later on 19 August 2020 he was found to require just such an urgent assessment and was said to be possibly psychotic.

196. I have not overlooked Mr Trusted's submission based on *Bolitho* that any expert evidence in C's favour would be bound to be discounted. However, that seems to me to impose quite a high threshold which I do not consider D1 has surmounted. I am not prepared to say at this stage that any such evidence would carry no weight even without seeing it.
197. Turning to causation, it seems to me that this is inter-linked to the issue of breach. If C's expert evidence were to be to the effect that on 12 August 2020, and certainly by 15 August 2020, C should have been assessed as requiring compulsory admission to hospital then that would raise a triable issue C would or might not have been at liberty to harm himself on 19 August 2020.
198. It may be that C's admission that he jumped because of the breakup with his girlfriend, and the other matters relating to causation relied on by D1, will prove insuperable for him in terms of causation. However, at this stage my conclusion is that this matter is one that is properly to be assessed by reference to evidence.

Conclusion

199. For these reasons, D1's applications fail and are dismissed. There will be judgment for D2 in the terms that I have indicated.