Neutral Citation Number: **[2025] EWHC 272 (KB)**

Case No: QB-2022-MAN-000106

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
MANCHESTER DISTRICT REGISTRY

The Civil Justice Centre Manchester

Date: 7 February 2025

Before :

His Honour Judge Bird sitting as a Judge of this Court

- -

Between :

MARK DOBSON **(a protected party by his litigation friend Mrs Anne Dobson)**	**Claimant**
- and -	
THE CHIEF CONSTABLE OF LEICESTERSHIRE POLICE	**Defendant**

- -
- -

Mr Marc Willems KC and Mr Philip Simms (instructed by **R James Hutcheon Solicitors**) for the **Claimant**
Mr Andrew Warnock KC and Mr Edwin Buckett (instructed by **DWF Law LLP**) for the **Defendant**

Hearing dates: 7,8,9,11 & 15 October 2024

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Approved Judgment

This judgment was handed down remotely at 10.30am on 7 February 2025 by circulation to the parties or their representatives by e-mail and by release to the National Archives

His Honour Judge Bird :

Introduction

1. Mr Dobson is an insulin dependent diabetic. At the time with which this claim is concerned, he lived a chaotic life, was a drinking alcoholic and a drug user. He was essentially homeless and chose to live in an adapted outbuilding. It is plain from the evidence I have heard and read that he had friends and family who cared deeply for his welfare.

2. He took an overdose of insulin on or about Christmas Day in 2018 and suffered life changing injuries as a result. In the days running up to Christmas he had had a number of interactions with the police in Leicester. On 23 December 2018, the police attended the shed having been told he had made a threat to take his own life by overdosing on insulin. He was arrested and taken to Keyham Lane police station. He was released without charge on 24 December 2018.

3. This claim has been brought because the Claimant (who acts though his mother and litigation friend Mrs Anne Dobson) asserts the Defendant failed in his duties towards him not least because he was released back to the shed with insulin and syringes and without any real or effective mental health assessment.

Chronology

Conviction at Coventry Magistrates

4. On 13 December 2018 he was convicted at Coventry Magistrates Court of driving whilst disqualified and sentenced to 12 weeks imprisonment suspended for 12 months. A curfew requirement was imposed for a period of 8 weeks with electronic tagging, and he was required to be at this parents' address overnight. At some time thereafter, but before 21 December he was fitted with a monitoring tag.

Events on 20 December 2018: Mr Dobson is taken to hospital

5. On 20 December, an ambulance was called to assist when Mr Dobson was found lying unconscious on a roundabout on Abbey Park Road in Leicester. On arrival the ambulance crew found him to be "*agitated and confused*". He became aggressive towards the ambulance crew and the police were called. Mr Dobson was arrested and taken to Leicester Royal Infirmary in a police van with the ambulance following. I was shown body worn camera footage showing Mr Dobson's arrival at hospital and some of the stay. He was insisting on having legal representation present at the hospital and was plainly agitated and concerned.

Events on 21 December 2018: Mr Dobson is taken to Euston Road police station

6. Mr Dobson was released from hospital and taken to Euston Road police station. He was booked in at 3am. He reported that he suffered from depression and anxiety but did not take medication. When asked if he had tried to harm himself, he replied that he had the last occasion being "*about one year ago*" when he stabbed himself in the arm. He recorded "*no current thoughts*" of self-harm. He was subsequently charged with 8 offences including assaulting 2 police officers and 2 paramedics, public order offences and criminal damage to property at Leicester Royal Infirmary. He was released at 4.37pm on bail to appear at Leicester Magistrates on 7 February 2019.

Events on 21 December 2018: Mr Dobson visits Great Arler Road

7. On 21 December 2018, Mr Dobson visited his parents and left their address "very distressed". At around 22.37 that evening the police were called to Great Arler Road where Mr Dobson was found at the home of a friend in a state of intoxication. He had deliberately cut his wrist with a pocketknife in an act of self-harm. PC Anthony Brewin attended. I have seen body worn camera footage of the incident, and a photo Mr Dobson took of the wound to his wrist. I also heard evidence from PC Brewin. It is plain that Mr Dobson was not seriously injured and was certainly not in any imminent danger of death, however it is equally plain that he required hospital treatment.

8. Mr Dobson was uncooperative, obstructive, and refused to go to hospital so his wrist could be looked at. He did allow the paramedic crew to test his blood sugar levels. They were low and as a result he required urgent hospital care. He again refused to go to hospital. He was found temporarily to lack capacity and force was used to take him to hospital. He was restrained in the ambulance and was aggressive. No arrest was made and no charges followed. He was released from hospital.

9. At 0048 on 22 December 2018, medical staff from the Leicester Royal Infirmary contacted the police because Mr Dobson was refusing to leave the hospital and "*refusing to engage with anyone over his mental health*". He was deemed to be competent. At 0152 it appears that Mr Dobson was re booked for a mental health assessment, but there is no record of any such assessment being completed. He attended Mansfield House Police Station at 1.39pm to make a complaint about his treatment.

10. Mr Dobson's father's evidence is that Mr Dobson went back to the family home on 22 December 2018 and spent the night there. He was agitated and angry.

Events on 23 December

11. On 23 December 2018 Mr Dobson contacted his girlfriend who was on route to China, making it plain that he intended to end his own life by taking an overdose of insulin. She contacted Mr Dobson's mother who made a 999 call at 8.27pm. I have listened to a recording of the call. Officers were dispatched to the cow shed where Mr Dobson was living, and Mr Dobson's father made his way there to support his son. PC Jayme Cooper and PC Christopher Vickers answered the

radio call to attend. I heard evidence from both. PC Cooper is now a Police Sergeant. On route, in separate vehicles, the officers were told over the radio of "*warning markers*" relating to Mr Dobson for possession of weapons (a lock knife) and health markers in respect of his type 1 diabetes and "*mental disorder*" for anxiety and depression. He had a history of being violent to police officers and other emergency workers and in 2017 he had stabbed himself in the arm. The officers were told about his threat to overdose on insulin.

12. PC Cooper arrived first and entered the shed which is described in a subsequent report as "*a stone built single storey barn with timber entrance door. Inside is a black leather sofa facing towards the door, located in front of that was a gas heater*". He noticed an insulin pen, empty cans of alcohol, petrol driven generators and a smell of petrol in the air. He saw an unsheathed samurai sword, a black pistol on top of the gas heater and a rifle with a scope.

13. As PC Cooper left the shed, he saw Mr Dobson approaching carrying another petrol can. Mr Dobson became aggressive and was shouting to the officers to leave the shed. PC Cooper arrested him on suspicion of possession of an offensive weapon and for possession of illegal firearms. He complied with the officers' requests, was handcuffed and then detained in a police van. He was subsequently de-arrested on the offensive weapon charge and arrested in respect of a public order offence and in respect of a malicious communication sent to his mother.

14. Mr Dobson's father's uncontested evidence is that he told the officer in charge at the scene (although there is some doubt as to the identity of that officer) that "*Mark needed to be sectioned for his own good*".

15. PC Vickers and PC Cooper recalled that a third, more senior officer, Inspector Botte turned up at the scene. It seems likely that he spoke to Mr Dobson's father.

16. It is important to note that Mr Dobson was not detained under the Mental Health Act. He was arrested.

Custody at Keyham Lane

17. Mr Dobson was taken to Keyham Lane custody suite and arrived at 10pm. He was noted to be drunk. PC Cooper dealt with the handover to the Custody Sergeant (PS Crisp, who is now a Police Inspector). I heard evidence from PS Crisp. He recorded in the custody log that Mr Dobson was an insulin dependent diabetic but had no insulin with him and had a cut to the left wrist as a result of self-harm. At 23.11 Mr Dobson requested a solicitor. At 23.47 the custody record notes that his details were passed to ZMS solicitors. They did not speak to Mr Dobson because "*he is too drunk*". None of the documents I have seen suggest that there was any mention at that early stage of the circumstances that led to arrest. PS Crisp told Jo Holland that he recalled that Mr Dobson had been arrested "*after making threats to himself*" but that the threats related to the use of petrol to set fire to himself and the use of firearms. He told me that he could not recall the risk of insulin overdose being raised.

18. PS Crisp completed a care plan at 23.32 noting the level of risk Mr Dobson posed to himself was "medium". He told Jo Holland that Mr Dobson was "*less than willing to assist [him] by answering questions at the desk*" so that he had to "*form the risk assessment on what was known [to him]*". He was seen by Cristina Burgui, a Health Care Professional ("HCP"), in his cell between 23.31 and 23.38 but refused any medical examination including a blood sugar test. She recommended that his insulin be collected from his home address (the shed) and brought to the station. He was noted to be slurring his speech and "*under the influence of alcohol*" but eating.

19. The care plan was updated and the level of observation increased from general observation to constant observation. His blood sugar was checked regularly, and he was given glucose gel.

20. At 0329 PC Cooper made an entry on the Police, Niche (internal reporting) system:

> *"Officers were called to a concern for welfare of a male who had sent a message to his ex-partner stating that he was going to overdose on insulin. The male had been in hospital the night before for an attempt at taking his life and is a known insulin user for type 1 diabetes making the threat more credible…. The male will require a mental health assessment prior to being fit for release due to his suicidal tendencies. Dobson has been challenging whilst in custody and uncooperative throughout."*

21. A Novorapid Epi Pen was brought (probably from the shed) before 0550 but was found to be virtually empty and to have a bent needle. At around 0800, Mr Dobson said he had more insulin at his parents' address.

22. PS James took over as Custody Sergeant at about 0630. He left a message for the Mental Health Team ("MHT") at 0803 "*asking to ensure they come and see him to establish if he needs admission/sectioning or processing CJT/ remanding*". At 0915 PS James spoke to MHT and was told that Jo Starbuck would attend in person.

23. At 0919, six vials of Novorapid insulin and a Glargine disposable pen were collected from Mr Dobson's parents' home by PC Wallace and brought to the police station. Mr Dobson's brother James was at the house and allowed the officer to search through Mr Dobson's belongings to find the insulin. The pen was found to be virtually empty. At 1002 Jo Starbuck, a mental health care professional from the MHT arrived. The notes she entered onto the custody record, are as follows:

> "*MHT - attempted to engage with [Mr Dobson] and complete a mental health assessment but [Mr Dobson] refused to engage, he answered monosyllabically to questions that were asked. He is known historically to mental health services having been assessed by mental health team at A&E and CRHT in 2016, at the time of assessment he was struggling with alcohol/drug use and relationship breakdown with thoughts of self-harm. He was signposted to services that could support him.*

> *He made it clear that he had no interest with speaking me currently (sic), unable to ascertain mental state or risk to self or others. He did not appear to be distracted, preoccupied or show any evidence of thought disorder, fully orientated to time place and person."*

24. Mr and Mrs Dobson told Jo Holland, the investigating officer, when she saw her on 6 February 2019, that Mark Dobson "*constantly refused to engage with mental health practitioners and would never accept help*".

25. At 1044 Mr Dobson told the Custody Sergeant (PS James) that he needed an epi-pen to administer the insulin. Sarah Nash, a nurse and HCP told Jo Holland that the Novorapid vials could either be inserted into an epi-pen or used with disposable syringes. I heard evidence from Miss Nash. No epi-pen was available and there were no syringes in the police station. Ms Nash therefore bought a pack of 10 disposable diabetic syringes from a pharmacy (the smallest pack size available), using Police petty cash. The syringes would be enough for 3 days. She told Jo Holland there was concern that if Mr Dobson was released from custody (at that time the position was not clear) he would be unable to obtain either insulin or the means to administer it. Buying the syringes meant that Mr Dobson could be released with his own insulin and would have the means to administer it over Christmas. She noted that if Mr Dobson could not administer insulin, he would "*become unwell at least and potentially die if not treated*". If he was not released, the syringes would be used whilst he was in custody. She placed the insulin and the syringes in Mr Dobson's locker "*to be used in custody during this detention or to be released with them*". She noted that "*in my role of healthcare professional I have a duty of care towards those I provide care for, it is essential that a type 1 diabetic has insulin and the equipment to administer it. That would include ensuring Mr Dobson had the provisions or ability to timely access provisions to manage his diabetes*". Ms Nash observed Mr Dobson as he administered a dose of insulin at 11.43.

26. Mr Dobson was interviewed by PC Wallace and PC Gear between 1346 and 1405. His solicitor, Anita Ruparell of ZMS solicitors was present. Three potential offences were put to him: possession of a firearm without a valid certificate, a public order offence and sending a malicious communication. He was asked if he had made a threat to overdose on insulin but refused to comment. I have seen a transcript of the interview and heard the interview. Mr Dobson is lucid. He engages with the interviewing officers and provides carefully considered answers. By way of example, he is asked about the cowshed by PC Wallace:

> *PC Wallace: could you tell me about the contents of the building?*
>
> *Mr Dobson: We haven't got time for that.*
>
> *PC Wallace: OK, but roughly, could you tell me what was in it?*
>
> *Mr Dobson: Yes, if you've got a couple of hours then yes, we can sit here, and I can list off the contents of the building. If you want to ask me about the contents, something specific, in the context of the building, I'll answer that question for you.*

27. At 1450 Ms Nash told Jo Holland Mr Dobson refused to have his blood sugar tested and declined further insulin.

28. At 1509 PS White (now DI White) took over as Custody Sergeant. He told Jo Holland that "*almost immediately after this handover I was informed by PS Phillips that there was insufficient evidence to charge Mr Dobson with the offences for which he had been arrested. At this point, I have no explicit power to detain a person…*". He felt it would be appropriate to extend Mr Dobson's period of detention so that he could "*consider the pre-release risk assessment properly and explore all feasible operational steps that could be taken*." PS White told me that he called the MHT because he had read the Niche report and was aware of the threat to use self-harm using insulin.

29. PS White told Jo Holland that he wanted some further background information from MHT, so he called them. They were willing to come back to the custody suite and assess Mr Dobson if he was prepared to co-operate. The custody record notes that PS White asked if Mr Dobson wanted to speak with the MHT, but he refused. The custody record records the conversation with the MHT (at 15.53) as follows: (references to "DP" are to Mr Dobson or the "detained person"):

> *"Spoken with MH team regards DP as he has refused to see them - he stated he wanted to leave so that he could have a cigarette. On the Niche crime report* [see the report set out above entered at 0329] *there is mention that the DP made an attempt on his own life the night before last. I have checked with the mental health team and there is no record of this on health systems so is unlikely to be true. Prior to this there is no contact since 2016 where he sent a photo of a cut to a third party whilst intoxicated. He did not remember doing this. DP was referred to the crisis team where he was assessed and referred back to his GP and for some counselling. No further interactions until last night's incident. DP was in custody on 21/12/18 and it was not felt necessary for the DP to be seen by MHT - no details on the pre-release risk assessment of any concerns/ referrals/ actions taken. He was charged and bailed from the station. He liaised with PS Phillips there is no suggestion of an attempt to self-harm during the incident last night from which the DP was arrested-he had been to the garage and purchased petrol for his generator - this suggests an element of forward planning. I have asked PS Phillips ensures that the relevant referrals are made off the back of the niche report. DP will be taken home by officers. MHT suggest providing him with the 24/7 MH Crisis Helpline number"*

30. PS White told me that when he spoke to the MHT he understood they had seen the Niche report and so were aware of the reason for the 999 call that lead to his arrest. In his witness statement he expressed the view that if Jo Starbuck had felt an urgent mental health assessment was required, she would have said so.

31. He told Jo Holland that he had looked into the possibility of Mr Dobson being returned to his parents' address but was told that was not possible. At 1614 there

was a pre-release risk assessment completed by PS White in the form of responses to given questions as follows:

> ***Detainee age, sex or other vulnerability? Yes. Details****: alcoholic/ type 1 diabetes- insulin dependent- has been seen by the HCP in custody. Referrals made by officers from niche report.*
>
> ***Physical or mental health? Yes. details:*** *cut to left wrist from previous self-harm refused to engage with mental health team in custody despite being offered twice. Previous history checked and MHT advise giving helpline number.*
>
> ***Threats of suicide/self-harm? Yes. Details:*** *message alleged to have been sent during incident. Petrol was for generators. PS Phillips confirmed no suggestion of suicide/ self-harm during this involving either the firearm or petrol. Weapons have been seized from the location to assist safeguarding. Mental health team offered twice and refused to engage- advice given reference help* line.

32. Mr Dobson appears to have been discharged from custody at 1626. At 1635 PC Wallace copied and pasted the content of an e-mail into the NICHE reporting system. The email had been sent to him by PS Phillips who was overseeing the investigation. The entry contains an explanation as to why Mr Dobson would not be charged. The note includes the following:

> *"The main issue is his mental health; he has refused to see the MHW, and the custody Sergeant has agreed he can go back to the garage. The officers are facilitating the transportation, the parents have been contacted and now refusing to accommodate him at their house. The officer is complete the PPN as a safeguarding measure. The decision is to NFA [take no further action] due to evidential difficulty."*

33. The PPN (or personal protection notice) was completed by PC Wallace at 1600. PC Wallace (now acting as a sergeant) told me in evidence that it would go to the Police adult safeguarding team. They receive information and distribute it as they deem necessary. The mere completion of a PPN does not guarantee third party action. He also explained (as is recorded in the PPN) that on release "all options surrounding housing" were considered with Mr Dobson. He refused any help, said if he was dropped off at a hostel he would leave and expressed a clear view to return to the cow shed where he had "a sofa and warmth".

34. On 25 December 2018, Mr Dobson took a near fatal dose of insulin as a result of which he suffered a very significant brain injury. He had sent messages to his girlfriend and others at around 5pm on 24 December 2018 with images of loaded insulin syringes and a part empty bottle of vodka with the captions: "*luckily the police supplied me with the necessary equipment to finish the job*" and "*this should do it*". He was found at the cowshed by a friend, Mr Daimon Swain, on Christmas Day 2018.

Summary of interactions with Mr Dobson from 13 December 2018 to 24 December 2018

35. In this period Mr Dobson interacted with the Magistrates Court and was sentenced for an offence, dealt with health care professionals at hospital between 20 and 21 December, with police at Euston Road station on 21 December 2018 when he was charged with a number of offences and again with police and the hospital on 21 and 22 December 2018. Whilst in custody at Keyham Lane he interacted with HCPs interested in his physical and mental health, with a solicitor and with a number of officers.

36. It appears to be common ground that at all times, except for a period on 21 December when he was deemed to lack capacity, Mr Dobson was fit to be detained, fit to be interviewed, fit to be charged and had no need for the services of an appropriate adult.

The investigation and the evidence gathered

37. The matters concerning Mr Dobson's injuries were referred to the Independent Office for Police Complaints ("IOPC") on 27 December 2018. On 9 January 2019, the IOPC directed that the matter should be investigated locally. Mrs Jo Holland, an investigator in the Defendant's Professional Standards Department was appointed to conduct a review in particular of the circumstances of the contact and involvement of Leicestershire Police prior to Mr Dobson's injuries to determine whether the decision to release Mark Dobson from custody "in possession of syringes for the administering of insulin was appropriate in light of his recent attempts to self-harm", whether the decision to release Mr Dobson "when he was vulnerable and had no support network in place and no permanent address was the correct one" and whether or not interactions with the Defendant's officers "may have caused or contributed to the serious brain injury arising from [the overdose] and where this is considered to be the case to conduct a detailed examination of such".

38. The relevance of the investigation is not the findings it makes but the evidence that was given to it.

The evidence I heard and the evidence I did not hear

39. I heard lay evidence form PC Brewin, PS Cooper, PC Vickers, Inspector Crisp, PS Wallace, Inspector White, retired PD Phillips and Miss Nash. I did not hear from Jo Starbuck.

40. I formed the view that each of the witnesses was telling the truth and doing the very best they could to assist me.

41. I was invited to draw adverse inferences from the absence of any evidence from Jo Starbuck. I am satisfied that it would not be right for me to do so. I

reach that view having regard to guidance given by Lord Leggatt JSC in *Efobi v Royal Mail Group* [2021] UKSC 33 at paragraph 41. It is important that Jo Starbuck made an entry in the custody record pursuant to her duty as a medical professional. It represents the results of her interaction with Mr Dobson and is akin to an entry in medical records. There is much to be said for taking that record, placing it in context and considering how it helps without oral evidence from the maker. It is in my judgment doubtful that supplementing such a record with oral evidence of what was observed (or felt) at the time but not recorded would be helpful. It may have been helpful to understand what Jo Starbuck's general approach to such examinations would have been, but the fact that evidence might have been helpful does not mean that its absence should lead to an adverse inference.

Expert evidence

42. I heard from Dr Mischa Mockett, a consultant child and adolescent psychiatrist and Dr Dinesh Maganty a consultant forensic psychiatrist. Dr Mischa Mockett was instructed by the Claimant, Dr Maganty by the Defendant.

43. The experts were invited to express a view on Mr Dobson's mental health during the period of his detention. In particular to say whether his condition was such that he ought to have undergone a full mental health assessment and if so, what would the outcome have been?

44. I formed the clear view that Dr Maganty approached the matter by reference to what was happening whilst Mr Dobson was in custody and in particular, how he was behaving at that time. Dr Mockett was far more interested in Mr Dobson's history than in how he would have appeared to the Police and to mental health professionals ("MHPs") when he was detained. Dr Maganty expressed the view in the joint report that diagnosis of a mental disorder requires "*contemporaneous evidence of diagnostic features being manifest*". Such features might include disordered thoughts, abnormalities in perception, behaviour or mood. Dealing with Dr Mockett's reliance on historical observations, Dr Maganty notes that these observations are recorded "*by lay people and not by mental health professionals*". He notes that behavioural traits linked to views on Mr Dobson's mental health (for example violence) are much better explained by substance abuse and improper control of his diabetes. He notes that "*violence is not a symptom of mental illness/disorder*".

45. The experts were asked to express a view on the circumstances that would trigger a mental health assessment. Dr Maganty's response is based on his own experience and knowledge of how in custody Mental Health Act assessments work in practise. Dr Mockett told me that in order to answer the question he had conducted an internet search. It was pointed out to him in cross examination that the website he consulted (which he very properly set out in the joint report) shed no light on the proper approach to be followed when a person was detained in police custody. He told me he had conducted the Internet search because he was looking "*for a clear definition*".

46. I formed the clear view that Dr Maganty's approach was to be preferred in every respect over that of Dr Mockett. Dr Maganty has relevant experience of the matters in respect of which he was giving evidence, and his approach was rightly centred on how Mr Dobson was during the period of his detention. Dr Mockett's main experience is in child and adolescent psychiatry and whilst he has some experience of dealing with persons who are in custody he is not a forensic psychiatrist.

The Law and relevant guidance

47. The role of a custody officer (who must hold at least the rank of sergeant) is very important. By section 37 of the Police and Criminal Evidence Act 1984 ("PACE") a custody officer must determine whether there is sufficient evidence to charge a detained person with the offence for which that person was arrested. The custody officer may detain that person at the police station for such period as is necessary to enable him to do so. If the custody officer determines that there is no such evidence and relevant preconditions for bail are not satisfied the arrested person must be released without bail. The obligation to release appears to be subject to a number of exceptions.

48. Section 66 of PACE requires the Secretary of State to issue Codes of Practice in connection with a number of things. Code C deals with the detention and treatment of persons by police officers. The following provisions of the Code were cited to me:

    i) 2.3 *the custody officer is responsible for the custody record's accuracy and completeness and for making sure the record or copy of the record accompanies a detainee if they are transferred to another police station. The record shall show: the time and reason for transfer; time a person is released from detention*

    ii) 2.4A *where a detainee leaves police detention or is taken before a court they, their legal representative or appropriate adult shall be given on request, a copy of the custody record as soon as practicable. This entitlement lasts for 12 months after release.*

    iii) 9.4 *when arrangements are made to secure clinical attention for a detainee, the custody officer must make sure all relevant information which might assist in the treatment of the detainee's condition is made available to the responsible healthcare professional. This applies whether or not the healthcare professional asks for such information. Any officer or police staff with relevant information must inform the custody officer as soon as practicable.*

    iv) 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*

v) 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:*

a) any risks or problems which police need to take into account when making decisions about the detainee's continued detention

b) went to carry out an interview if applicable and

c) the need for safeguards

vi) *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.*

vii) Annexe E provisions relating to vulnerable persons at paragraph 5 *the custody officer must make sure a person receives medical 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.*

49. A document produced by the College of Policing provides further guidance:

i) *custody officers need to be aware of the enhanced risk of suicide and self-harm during periods of detention. Factors which may indicate an increased risk include mental ill health including depression, drug alcohol or substance abuse or withdrawal, breakdown of social support and isolation, being unemployed, and previous episodes of deliberate self-harm.*

ii) Under the heading "release from custody" *custody officers should complete a pre-release risk assessment. They should not leave this until the point of release. Instead, it should be an ongoing process throughout detention and be concluded at the point of release. Custody officers should refer to all existing risk assessment information for the detainee. They should also personally speak to all detainees prior to release and consider the risk of exploitation and/ or victimisation of the detainee. Custody officer then needs to decide what action, if any, is appropriate to support vulnerable detainees upon release.*

iii) Under the heading risk of self-harm and suicide after release, *there are occasions when it becomes apparent through pre-release risk assessment that a detainee is extremely vulnerable and that there is a*

real incredible risk to that individual on release (including the risk of suicide). The custody officer has no explicit powers to detain a high risk detainee before/ without charge once their detention can no longer be authorised, in accordance with part 4 of PACE or any other lawful power. They may consider using section 135 or 136 of the Mental Health Act 1983 (if the legislative criteria are met at point of release)…. The custody officer responsible for the duty of care for that detainee has to make a decision on the best course of action for the detainee on release and, under exceptional circumstances, the safest course of action to protect the life of that individual.

iv) In the same section: *similarly, a person may be detained if they are in need of mental health assessment and thus detention in custody after the criminal matter has been dealt with…. The reasons for not releasing someone are*

a) police have a common law duty of care to the detainee

b) police have a duty to release into a safe environment

……a person may also be kept for a minimal and limited period to allow for the transfer of care to other appropriate care services, for example transfer into social services or local hospital care facilities.

It is unlikely that a referral will be legally permitted without the explicit consent of the detainee unless there is a legal obligation to inform others. Where there is a legal requirement to make a referral, but the referral has been made without the consent of the individual, officers should record the reason and justifications for this in the custody record.

50. Section 13 of the Mental Health Act provides as follows:

(1) If a local social services authority have reason to think that an application for admission to hospital or a guardianship application may need to be made in respect of a patient within their area, they shall make arrangements for an approved mental health professional to consider the patient's case on their behalf.

(1A) If that professional is—

(a) satisfied that such an application ought to be made in respect of the patient;

and

(b) of the opinion, having regard to any wishes expressed by relatives of the

patient or any other relevant circumstances, that it is necessary or proper for

the application to be made by him, he shall make the application.

(1B) Subsection (1C) below applies where—

(a) a local social services authority makes arrangements under subsection (1)

above in respect of a patient;

(b) an application for admission for assessment is made under subsection (1A)

above in respect of the patient;

(c) while the patient is liable to be detained in pursuance of that application, the

authority have reason to think that an application for admission for treatment

may need to be made in respect of the patient; and

(d) the patient is not within the area of the authority.

(1C) Where this subsection applies, subsection (1) above shall be construed as requiring the authority to make arrangements under that subsection in place of the authority mentioned there.]

(2) Before making an application for the admission of a patient to hospital an approved mental health professional] shall interview the patient in a suitable manner and satisfy himself that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.

(3) An application under subsection (1A) above may be made outside the area of the local social services authority on whose behalf the approved mental health professional is considering the patient's case.]

(4) It shall be the duty of a local social services authority, if so required by the nearest relative of a patient residing in their area, to make arrangements under subsection (1) above for an approved mental health professional to consider the patient's case] with a view to making an application for his admission to hospital; and if in any such case [that professional] decides not to make an application he shall inform the nearest relative of his reasons in writing.

(5) Nothing in this section shall be construed as authorising or requiring an application to be made by an [approved mental health professional] in contravention of the provisions of section 11(4) above [or of regulations under section 12A], or as restricting the power of [a local social services authority to make arrangements with an approved mental health professional to consider a patient's case or of] an [approved mental

health professional] to make any application under this Act.

51. Section 136 of the Mental Health Act sets out the following:

> *(1) If a person appears to a constable to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons—*
>
> > *(a) remove the person to a place of safety within the meaning of section 135, or*
> >
> > *(b) if the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety.*
>
> *(1A) The power of a constable under subsection (1) may be exercised where the mentally disordered person is at any place, other than—*
>
> > *(a) any house, flat or room where that person, or any other person, is living, or*
> >
> > *(b) any yard, garden, garage or outhouse that is used in connection with the house, flat or room, other than one that is also used in connection with one or more other houses, flats or rooms.*
>
> *(1B) For the purpose of exercising the power under subsection (1), a constable may enter any place where the power may be exercised, if need be by force.*
>
> *(1C) Before deciding to remove a person to, or to keep a person at, a place of safety under subsection (1), the constable must, if it is practicable to do so, consult—*
>
> > *(a) a registered medical practitioner,*
> >
> > *(b) a registered nurse,*
> >
> > *(c) an approved mental health professional, or*
> >
> > *(d) a person of a description specified in regulations made by the Secretary of State.*
>
> *(2) A person removed to, or kept at, a place of safety under this section may be detained there for a period not exceeding the permitted period of detention for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care.*
>
> *(2A) In subsection (2), "the permitted period of detention" means—*

(a) the period of 24 hours beginning with—

(i) in a case where the person is removed to a place of safety, the time

when the person arrives at that place;

(ii) in a case where the person is kept at a place of safety, the time when

the constable decides to keep the person at that place; or

(b) where an authorisation is given in relation to the person under section 136B, that period of 24 hours and such further period as is specified in the authorisation.

(3) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the permitted period of detention mentioned in subsection (2) above, take a person detained in a place of safety under that subsection to one or more other places of safety.

(4) A person taken to a place of a safety under subsection (3) above may be detained there for a purpose mentioned in subsection (2) above for a period ending no later than the end of the permitted period of detention mentioned in that subsection.

(5) This section is subject to section 136A which makes provision about the removal and taking of persons to a police station, and the keeping of persons at a police station, under this section.

The Claim

52. Mr Dobson's general pleaded case (see Particulars of Claim at paragraph 17) is that the Defendant "*assumed responsibility to protect [him] from harm*" and so owed him a duty of care. He pleads that the Defendant ought to have arranged a full mental health assessment under section 13 of the 1983 Act and used either the statutory power under section 136 of the Act or a common law power (see paragraphs 32 to 34 and *R (oao Munjaz) v Mersey Care NHS Trust* [2003] EWCA Civ 1036) to detain him pending that assessment. He pleads that the Defendant ought to have been alerted to the need for an assessment because he had refused to engage with Jo Starbuck (paragraph 37).

53. The broad case on breach is (paragraph 39) that the Defendant failed to treat him as a suicide risk and failed to ensure that he was properly assessed by a mental health professional. Some 26 specific allegations of breach (or of negligence) are pleaded. There is a great deal of overlap in the allegations. In summary they are based on the matters set out above, that more ought to have been done when Mr Dobson was in custody, that his detention ought to have

been extended and that he should have been taken to a safer location with a plan for the supply of insulin over the Christmas period.

54. The claim is based squarely on the Defendant's failure to act. Had the Defendant detained him, he would have been protected and would not have harmed himself after he was released from custody. If I find that the Defendant owed a duty to Mr Dobson and has breached it, then I must consider the extent to which Mr Dobson eventual damages should be reduced (if at all) by reason of contributory negligence.

55. Article 2 of the Human Rights Act is pleaded but Mr Willems KC accepted that it did not give rise to a liability that would not arise in respect of a negligence claim. I return to Art.2 below.

Submissions

56. In written opening submission Mr Dobson's case is put squarely on the basis that the Defendant assumed responsibility to take reasonable care to keep Mr Dobson safe. The Defendant then acted in breach of that responsibility (or duty) by allowing him to be released before he had gone through a mental health assessment. If such an assessment had been carried out it would have resulted in his further detention under section 136 of the 1983 Act (paragraphs 5.2 and 8)

57. Further it is said that all relevant information was not taken into account when the pre-release risk assessment was carried out. In particular warnings from Mr Dobson's father that he needed to be sectioned and PC Cooper's view that he would need a mental health assessment were ignored. If the risk assessment had been concluded correctly there would have been a mental health assessment (paragraphs 5.4 to 6). The requirement for a mental health assessment also arose under PACE code C (paragraph 5.11)

58. Jo Starbuck's interaction with Mr Dobson did not amount to a mental health assessment (paragraph 5.6) and could not have done so because she was not fully instructed (paragraph 5.13).

59. The Defendant accepts (see paragraphs 33 and 36 of his skeleton argument) that he owed Mr Dobson a duty to keep him safe when in custody but denies that the scope of that duty extended to the post release period. At paragraph 39, it is submitted that the Defendant "*did not assume a duty investigate, diagnose and treat any mental health condition which he may have had (if in fact he had one at all)*".

Duty

60. The Defendant is a public authority. Public authorities (like private individuals) are generally under no duty to protect a person from harm suffered as a result of the actions of a third party or as a result of their own actions. To put it another way, they are under no general duty to protect

someone from themselves or from a third party. This general rule does not apply (and so a duty may arise) if the public authority assumes responsibility to protect that person (*Robinson v CC* at 34). For that reason, the question of whether there has been an assumption of responsibility is key to the outcome of this claim (see also *HXA v Surrey* reported with *YXA v Wolverhampton* [2023] UKSC 52 at paragraph 88 where the same approach is expressed, *Reeves* at p.379H and *Lukes v Kent & Medway* [2024] EWHC 753 at para.129 to 130).

Assumption of responsibility

61. I accept (and the Defendant admits) that he assumed responsibility to take reasonable care to keep Mr Dobson safe whilst he was in custody. That is plain from *Reeves*. I accept that the duty extends to ensuring that Mr Dobson was released into a safe environment. The act of release is in effect, part of detention. The real question is whether the assumption of responsibility remains once Mr Dobson was released, or to put it another way, once the Defendant ceased to exercise "*complete control*" over Mr Dobson.

62. The decided cases lay down no hard edged test that can be applied to determine if a Defendant has assumed a relevant responsibility towards a Claimant. In *HXA v Surrey* (a strike out case) the Supreme Court explain (see paragraph 90) that the precise test varies "*according to the general context*".

63. *YXA* was concerned with harm suffered by children in care as a result of omission. In that context, the Supreme Court explained that a local authority (or a private person) will assume responsibility to use reasonable care to protect a child against harm (including from third parties) where the child's safety has been entrusted to the local authority (or private person) by the parents and the local authority (or private person) has accepted that responsibility.

64. The example of a child and a local authority is stark. A child is, by definition, vulnerable and lacks full autonomy. Parents (in the example) are responsible for the child's safety. If those with responsibility (the parents) pass it on to another who willingly accepts it, then it is easy to see that the other has assumed (or accepted) responsibility as a matter of fact (and law). The Supreme Court likens this to a delegation of responsibility.

65. *Reeves* is an example of assumption of responsibility (see *Lukes* at para.130 to 131). A duty is owed to protect a detained person in custody from harming himself. It arises because the police have "*complete control*" over the prisoner and because it is well known that there is a "*special danger*" that the detained person will self-harm (see *Reeves* at p.369A). *Reeves* presents another clear and extreme example. The detained person is vulnerable and (whilst they are detained) is robbed of meaningful autonomy because the police have assumed complete control.

66. In both *Reeves* and the example given in *YXA* the assumption of responsibility lasts only whilst the relevant person (the local authority or the police) has control. Once the child is returned to the parents, responsibility passes back to

them. Once the detained person (assuming they have capacity) is released, control and autonomy revert to them, and they become responsible for themselves.

67. The decided cases on Art.2 shed some light on the principle of assumption of responsibility. It is clear that the Art.2 operational duty (an obligation to actively protect a person) arises where the state (and in Art.2 cases the duty can of course only attach to the state) assumes responsibility for the safety and welfare of an individual. Paradigm examples arise where the state has detained a person (whether in prison, in a psychiatric hospital, in an immigration detention centre or otherwise) or where a person is conscripted into the army (see paragraph 22 of ***Rabone v Pennine*** [2012] UKSC 2). The Supreme Court emphasised that vulnerability is a relevant factor (paragraph 23) in deciding if the state has assumed responsibility for a person's wellbeing.

68. In Rabone, Melanie Rabone was admitted to hospital having been assessed as being at high risk of suicide. She was not detained, but her records noted that if she attempted to leave, she should be assessed for detention. She was allowed home for 2 days and 2 nights at a time when her risk of suicide was at least moderate to high. On the second day of home leave Miss Rabone took her own life. the Supreme Court found (see paragraph 34) that the state had assumed responsibility for her. Lord Dyson (with whom the other Justices agreed) said:

> *"She had been admitted to hospital because she was a real suicide risk. By reason of her mental state, she was extremely vulnerable. The trust assumed responsibility for her. She was under its control. Although she was not a detained patient, it is clear that, if she had insisted on leaving the hospital, the authorities could and should have exercised their powers under the MHA to prevent her from doing so…. In reality, the difference between her position and that of a hypothetical detained psychiatric patient, who (apart from the fact of being detained) was in circumstances similar to those of Melanie, would have been one of form, not substance. Her position was far closer to that of such a hypothetical patient than to that of a patient undergoing treatment in a public hospital for a physical illness."*

69. The Defendant in that case had admitted that allowing Miss Rabone to go home was negligent. The negligence claim had been settled. The Supreme Court was concerned with a claim by Miss Rabone's parents under Article 2 ECHR. That claim was necessary because (see Baroness Hale at paragraph 92) "*the ordinary law of tort does not recognise or compensate the anguish suffered by parents who are deprived of the life of their adult child*".

70. The finding that the State had assumed responsibility for Miss Rabone's wellbeing was based (as it was in ***Reeves***) on her extreme vulnerability and the degree of control the state (through the hospital) had over her.

71. Having considered circumstances in which there might be an assumption of responsibility it is useful to consider situations which have been authoritatively stated to be insufficient. The existence of a statutory power (or even a statutory

duty) permitting (or requiring) the public authority to prevent the harm, is not sufficient to find a duty is owed to a particular individual (***Robinson*** at 36). Often, statutory duties are owed to the public at large and statutory powers are designed to benefit the public at large. Neither is usually directed at any particular individual.

72. The starting point for any analysis is to determine what it is alleged the Defendant has assumed responsibility to take care to do. This question is described in HXA as an exercise that "*helps to sharpen up the analysis*" (paragraph 91). Mr Dobson's case, at a high level of generality, is that the Defendant's admitted assumption of responsibility to take reasonable care to keep him safe from his own actions continued after his release from custody and so after the Defendant had relinquished control over him.

73. In my view it is clear from the authorities that if the Defendant has ceased to exercise control over a Claimant, then the Defendant's assumption of responsibility has come to an end. However, the matter does not stop there.

74. The authorities suggest that (a) where responsibility for a vulnerable person is transferred with consent from one person to another the latter will have assumed responsibility for that person until the transfer ends and (b) where a vulnerable person is under the control of a body (actually as in ***Reeves*** or constructively as in ***Rabone***) the body will be taken to have assumed responsibility for them.

75. The first situation does not arise. There is no question of the Defendant having accepted responsibility for Mr Dobson from a third party.

76. Once Mr Dobson was released from custody he was no longer under the actual control of the Defendant. But, if the Defendant's officers "*could and should have exercised their powers"* (see Rabone paragraph 65 above) to prevent him from leaving (or to detain him under the Mental Health Act or otherwise), then it is arguable that he might be treated as under the control of the Defendant, just as Miss Rabone was treated as under the control of the hospital.

77. Mr Dobson's case in my view is exactly that: the Defendant could and should have continued to detain him and so could and should have continued to exercise control over him. Looked at in this way, some of the breach questions (should he have been detained?) become rolled up in the question of whether a post release duty exists.

78. I turn then to consider the bases on which it is said that Mr Dobson should have been further detained. Before dealing with the duty or power to detain it is necessary to consider Jo Starbuck's interactions with Mr Dobson.

What is the effect of Jo Starbuck's examination?

79. I accept that Jo Starbuck was not able to conduct a full and complete mental health assessment, in particular she was unable to ascertain Mr Dobson's

"*mental state*" or determine if he posed a risk to himself or others. I have however come to the view that her examination was sufficient to permit the conclusion that Mr Dobson was not suffering from any obvious active symptoms of mental illness. It is important to consider the context and ask why the examination was so limited.

80. It is clear that there was a fair degree of interaction. Questions were put to Mr Dobson, and he provided some (albeit inadequate, "*monosyllabic*") answers. In addition, Mr Dobson "*made it clear*" that he had no interest in engaging. I note that that is entirely consistent with Mr Dobson's general approach to mental health support.

81. Jo Starbuck had plainly considered relevant health records and noted that Mr Dobson had some interaction with mental health services in 2016. She noted that there was reference in 2016 to self-harm. There is no reference to any mental health diagnosis. I accept that Jo Starbuck had access to Mr Dobson's police records including the Niche reports so that she can be taken to be aware of the circumstances that led to Mr Dobson's arrest. In my view that is why in her note she refers to 2016 "*thoughts of self-harm*" and to an assessment of the risk he poses to "*self or others*".

82. I am prepared to proceed on the basis that Jo Starbuck discharged her duties as a medical practitioner appropriately. Indeed, it seems to me there is no basis on which I could properly come to any different conclusion.

83. The final conclusion was that Mr Dobson was not distracted or preoccupied, showed no evidence of thought disorder and was fully orientated to time, place and person. I take this to mean that Mr Dobson was able to focus and maintain attention, was not labouring under any persistent or dominant thoughts, had ordered thoughts, was able to identify where he was, the date and time and understood who he was. Dr Maganty points out in the joint report that the only sensible reading of these conclusions is that Mr Dobson was displaying no "[obvious] *active symptoms of mental illness*".

84. In my judgment Jo Starbuck conducted an assessment of Mr Dobson's general mental health. Based on her interactions with Mr Dobson, she had enough information to do so. It seems to me that PS White is right to say that if she had felt a full mental health assessment was required, she would have said so. That was, after all, why she was there. It follows that PS White was entitled to draw comfort from the examination when deciding on the next steps. I reject the (unpleaded) submission that Jo Starbuck was not properly instructed.

Did a power to detain Mr Dobson arise (under section 136 or as a matter of common law necessity)?

Section 136

85. Section 136 grants specific powers to the police (a constable). If the powers set out in that section are not exercisable it is difficult to see how the police

could instead invoke section 13. The latter section imposes an obligation on local social services authorities to make arrangements for an approved mental health practitioner to consider whether a person who is suffering from or appears to be suffering from a mental disorder (a "patient" see the definition at section 145) should be admitted to hospital.

86. It permits a constable, in certain circumstances, to take a person to (or keep a person at) a place of safety and detain them there for up to 24 hours (extendable to up to 72 hours) so that that they can be examined and, if appropriate, arrangements can be made for their treatment or care. The power only arises where "it appears to the constable" that the person is (a) suffering from "mental disorder" and is (b) in *immediate need of care or control*. If these 2 pre-conditions are satisfied, the constable may exercise the power if he thinks it is *necessary* in the interests of that person (or in order to protect others). Before exercising the power, the constable must (if it is practicable to do so) consult a mental health professional.

87. Plainly (see ***Robinson***) the mere existence of a statutory power or duty to act in a given way is not enough to establish that a body has assumed responsibility for a person's wellbeing.

88. Guidance issued by the Department of Health on 1 April 2015, makes it plain that the power (albeit then in a slightly different form and before there was a requirement to consult where practical) is an emergency power. It points out that consultation may lead to alternative options being identified (see paragraph 16.22). Home Office and Department of Health Guidance published in October 2017 (dealing with the up to date section 136 including the obligation to consult where practical) states that the purpose of the consultation is for the police officer, considering whether to use their powers under section 136, to obtain "*timely and relevant mental health information and advice that will support them to decide a course of action that is in the best interests of the person concerned*." As to the substance of the consultation, the guidance provides (paragraph 2.11) that it should include information and advice on whether the situation is in fact "*a mental health issue*" or where the physical health issues such as substance abuse may be the real concern. Consultation should also deal with the appropriateness of using section 136.

89. If the circumstances are such that a detained person may require a healthcare assessment, the police are entitled to (and in my view, must if the advice is available) rely on the advice and opinion of the healthcare professional carrying out the assessment and are not required to second guess the advice. The degree of co-operation offered by the detained person is irrelevant, as long as there is some attempt at some sort of assessment. The assumption underlying this approach is at least in part that a healthcare professional will adopt a nuanced and holistic approach to their task. Even if any offer of help is rejected (as it was in this case) the police are reasonably entitled to assume that a health professional would apply his mind to the need for further intervention and recommend it if it was required (see ***Lukes*** para.157 to 159).

90. At the point at which Mr Dobson was discharged (1626 on 24 December 2018) he had been displaying no "[obvious] *active symptoms of mental illness*" (on a proper understanding of Jo Starbuck's assessment) and there was no recommendation or suggestion, despite 2 interactions with the MHT, that it would be in his best interests to detain him for a further assessment. He had full capacity and had refused to engage with a full mental health assessment. There was no suggestion that he would change his mind about co-operating. It was his right not to co-operate. 30 minutes before release, it was noted that when he was arrested, nothing in his conduct suggested a desire to self-harm. There had been no threat to self-harm in custody and when asked about self-harm (including the threat to overdose on insulin) in interview he chose to give a "no comment" answer. He had eaten regularly whilst in custody. The only sign of moderate concern was that he had refused to have his blood sugar tested. Balanced against that was the fact that he had administered his insulin and had asked for the means to do that whilst in custody.

91. There was in my judgment no basis on which a constable (here, PS White) could conclude that Mr Dobson was in immediate need of care or control or that it was necessary to exercise section 136 powers to protect Mr Dobson from himself.

92. For those reasons in my view, if as matters stood at 1626 on 24 December 2018, PS White had detained Mr Dobson in purported exercise of section 136 powers, that detention would have been unlawful. PS White told me that he did not believe, at the point of release, that Mr Dobson was in "immediate need of care or control". I accept that evidence.

Necessity

93. In *Munjaz* (decided in 2003) the Court of Appeal was concerned with the lawfulness of the practice (known as "seclusion") of locking patients into their rooms at night. If the patient was detained in hospital under the powers set out in the Mental Health Act 1983, seclusion might be justified as part of the detention. If the patient was not detained, that justification could not apply. At paragraph 46 Hale LJ (as she then was) explained that seclusion might be justified in respect of a patient who had capacity (whether detained or not) on the ground of common law necessity. The Court of Appeal decision was overturned on appeal to the House of Lords. At paragraph 123, Lord Brown expressed the view that seclusion of a patient who was not detained, could not be justified on the ground of necessity. In such circumstances, seclusion would be a breach of Article 8 of the ECHR because the absence of any procedural safeguards would render the detention/seclusion "arbitrary".

94. In *R (Sessay) v South London and Maudsley NHS Trust* [2011] EWHC 2617 the High Court considered that the Mental Health Act provided a complete code in respect of the right to detain persons pending a mental health examination. It rejected the submission that the common law doctrine of necessity had any application. Of the 7 reasons given for the conclusion, the final one (see paragraph 45) was that detention under the common law would be arbitrary.

95. In my view there is no distinct common law right to detain a person pending a mental health assessment. Such a right would be arbitrary for the reasons explained in *Sessay*. Section 136 limits the circumstances in which a constable might remove and detain a person on mental health grounds. A common law provision expanding those rights would in my judgment defeat the legislative purpose of section 136.

Did the Defendant assume responsibility to protect Mr Dobson from self-harm after release?

96. In my judgment the answer is no. There is no delegation of responsibility and at the time Mr Dobson suffered injury he was not (either actually or constructively) under the control of the Defendant. My finding that Jo Starbuck conducted an appropriate mental health assessment is sufficient on its own to justify the conclusion that there was no assumption of responsibility for Mr Dobson's post release safety. If that is wrong, I have in any event found that there was no statutory or other basis to detain Mr Dobson.

97. In my judgment "*the general context*" of the claim makes it clear that there was no assumption of responsibility. There is no complaint about Mr Dobson's arrest and no doubt that he had capacity once he was sober. He made no threat of suicide whilst in custody, ate food he was given and took his insulin, having made arrangements for it to be collected. He engaged with his solicitor and with the interviewing officers. He displayed no obvious signs of mental illness (as judged by a MHP) whilst in custody. There was no basis in law to detain him once the decision had been taken to release him.

Was the pre-release risk assessment adequate?

98. The pre-release risk assessment made no express mention of the specific risk of releasing Mr Dobson with insulin. It did record that Mr Dobson was vulnerable, had physical or mental health issues and that he had made threats of suicide or self-harm. There was plainly some confusion about the mechanism he had threatened to use. The risk assessment appears to proceed on the basis that he would use the petrol he was carrying at the time of arrest. That was wrong. In each case there was an explanation of what steps had been taken to reduce the risk of harm arising from the particular risk factor. In respect of his vulnerability a PPN was completed (in my view the PPN is the "referral" referred to in the Niche report "as a safeguarding measure"), in respect of mental health issues and self-harm, advice had been sought from the MHT and he had been given "the helpline number".

99. In line with the College of Policing Guidance (paragraph 43 above), the custody sergeant spoke to Mr Dobson. The aim of the risk assessment (as made clear in that guidance) is to decide "*what action, if any, is appropriate to support vulnerable detainees on release*". In cases where there is a "*real and credible risk*" of suicide or self-harm but there is no basis for continued detention under PACE, the guidance suggests that thought be given to using the powers under section 136 or to considering if generally a mental health assessment is required.

100. On the facts known to the police on 24 December 2018, it cannot be said in my view there was anything approaching a real and credible risk of Mr Dobson self-harming. At its highest, and if there was such a risk, the risk assessment might have resulted in the need to consider exercising section 136 powers. For the reasons I have already given it would not have been appropriate to exercise those powers.

101. In my judgment the pre-release risk assessment was broadly adequate. It addressed the risk of suicide or self-harm and explained how the risk had been mitigated. In any event, even if I am wrong about that and the assessment was inadequate there would have been no mental health assessment for the reasons I have given.

102. Finally, I have come to the view that the views expressed by some officers and more importantly by Mr Dobson's father that he needed to be sectioned and cared for are not relevant. If those views are relevant at all they would in my judgment carry little or no weight. The views of others do nothing to detract from the conclusion that there was no basis for detention.

Release with Insulin

103. I am satisfied that Mr Dobson was released to the safest place available. He could not go to his parents and had expressly refused other options. He had made it plain he would leave any hostel he was dropped at and expressed the view that the cow shed was where he wanted to be. There was no sufficient reason to disregard Mr Dobson's wishes.

104. I am also satisfied that it was appropriate to release Mr Dobson with insulin and the means to administer it. In my judgment, on the facts as I have found them, there was no reason not to release Mr Dobson with the insulin and every reasons to do so. First, the insulin belonged to him and there was no reason to confiscate it. Secondly, he plainly needed the insulin and there was no reason to suspect he would use it in the way that he tragically did.

Standard and breach if there was a duty

105. If I am wrong about the existence of a duty, I am satisfied that the Defendant's officers did not act in breach of that duty. As is made clear in *Barrett v Enfield* [2001] 2 AC 550 (see paragraph 5 of the Defendant's closing submission) the question of breach requires that I consider the statutory context in which events unfolded and the nature of all relevant actions. The statutory context is at least twofold: first, the power to detain on mental health grounds is carefully circumscribed and calls for the exercise of judgment and the receipt of professional guidance and secondly, the right to detain after a decision to take no further action has to be exercised with great care. Both of these factors are part of the fundamental right every individual enjoys, that his right to freedom (non-detention) must be respected and safeguarded.

106. I have dealt in one way or another with the pleaded apparent breaches (at least as categorised by the Defendant at paragraphs 8 to 42 of his closing argument). None is made out.

Causation

107. If I am wrong about duty and breach, then the question of causation arises. I think it is unlikely, even if Mr Dobson was detained for further examination, that he would have been admitted to hospital for treatment or investigation.

108. Dr Maganty's view expressed in the joint experts' report was that on balance Mr Dobson would not have been detained had he been examined, because there was "*no active suicidal ideation in custody or active evidence of any severe mental disorder as was the case for years previously*". I accept that view.

Article 2

109. It was accepted that a consideration of Article 2 brings nothing new. I am satisfied that Article 2 was not engaged because, on the facts as known at release or just before, there was no evidence of a real and immediate risk of Mr Dobson taking his own life.

110. In those circumstances it is not necessary for me to consider the Article 2 limitation issue.

Conclusion

111. For all those reasons I must dismiss the claim. If I had allowed the claim, I would not have made any reduction for contributory negligence.

112. I am grateful to all counsel for their careful and skilful presentation of the arguments.