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Case No: HQ15P02428

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: Friday, 2nd August 2019

Before: **HIS HONOUR JUDGE SAGGERSON**
(Sitting as a Judge of the High Court)

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Between :

WAYNE WATLING	**Claimant**
- and -	
THE CHIEF CONSTABLE OF SUFFOLK CONSTABULARY (1)	**Defendants**
G4S HEALTH SERVICES (UK) LTD (2)	

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Mr Nick Armstrong (instructed by Irwin Mitchell) for the Claimant
Mr Adam Clemens (instructed by Weightmans) for the First Defendant
Mr Gurion Taussig (instructed by G4S Legal Department) for the Second Defendant

Hearing dates: 25th, 26th, 27th, 28th February 2019. 1st, 4th March 2019. 24th and 25th June 2019

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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Introduction

1. In the early hours of Sunday 18 May 2014 the claimant, having visited a friend in Saxmundham, was driving his car on the A12 in Suffolk. At the time he was fit and well. He was 49 years old. He left his friend's at about 1.30am and felt fine. As he approached the roundabout at Seckford Hall he was aware of feeling dizzy. He felt numbness in his right hand and was aware of disturbed vision. He found it difficult to focus. He was also aware that his driving was impaired and for this reason decided to head for the nearest garage to seek help. He knew something was wrong. By this time it must have been about 2.25am.

2. PC Jackaman was on police patrol duty driving a marked car with SC Moxon. As he approached the Seckford roundabout he became aware of the claimant's car. It was a blue Chrysler, registration number HV55 EWK. He noticed that the car was being driven erratically. Its speed was uneven, the brakes were being repeatedly applied and the car was swerving from side to side across the central road markings. On occasions it came very close to the nearside kerb.

3. PC Jackaman activated the blue lights on the police car and stopped the claimant. The claimant pulled over as required at the side of the road near the Martlesham roundabout. PC Jackaman approached the claimant to ask him to account for the manner of his driving. By now it was about 2.33am.

4. According to PC Jackaman the claimant was unable to produce any speech. He was unable to respond to questions and white, shiny phlegm was apparent around his mouth. The claimant's body and arm were shaking. He does not say which arm. There was no smell of alcohol about the claimant or from the interior of the car, and PC Jackaman could not see any signs of white powder. PC Jackaman had to help the claimant switch off his car engine. Even so, not unreasonably, he suspected that the claimant was driving under the influence of drink or drugs and so he requested a roadside breath sample. The testing device and procedure were explained to the claimant. The claimant understood and provided a breath sample. He "*only just*" managed it by blowing very gently. The reading was "nil". As a result, PC Jackaman formed the reasonable suspicion that the claimant's erratic driving was the result of his being under the influence of drugs even though there was no sign of any drugs paraphernalia in the car or about the claimant's person.

5. As a result, at about 2.37am, the claimant was asked to step out of the car and was arrested for driving a vehicle under the influence of drugs. The claimant struggled to get out of the car and had to be helped by PC Jackaman. He was unsteady on his feet. He was still unable to speak. However, PC Jackaman's impression was that the claimant understood what was being said to him. The claimant was handcuffed and helped into the police car. His own vehicle was secured, together with his possessions inside, and he was conveyed to the Martlesham Police Investigation Centre ("PIC"), arriving at about 2.40am.

6. In fact, the claimant had had a stroke. It later emerged that the claimant had suffered a brain attack caused by a thrombosis in the left internal carotid artery with subsequent

secondary embolization. It is described by Professor Chadwick (neurologist) as "*a complete anterior circulation stroke with occlusion of the internal carotid artery in the neck*". The onset of the symptoms occurred suddenly whilst the claimant was driving. But for the fortuitous intervention of the police at the roadside, triggered by the claimant's erratic driving, it is possible that the claimant would have caused an accident, potentially involving third parties, or remained isolated and unattended at the roadside. Had he presented himself, uncommunicative at a garage there is a good chance he would just have been regarded as drunk or drugged and the police called.

7. The claimant's detention at the PIC was authorised at 2.49am; he was searched at the PIC custody desk at 2.54am and taken to the PIC's dedicated room (the "intoximeter" room) for the administration of the station breath test procedure. At 3.04am PC Last telephoned G4S (the second defendant) asking for the attendance of a forensic medical examiner ("FME") for the purposes of there being a medical examination and forensic testing of the claimant for drugs. This medical assessment was not carried out for some hours. The FME (Dr. Klotins) conducted the assessment at about 5.40am or shortly thereafter. It was concluded at 6.05am. As a result, Dr. Klotins referred the claimant to the Ipswich Hospital for investigation for stroke or transient ischaemic accident ("TIA"). The claimant was conveyed to the hospital arriving sometime between 6.15am and 6.30am. The time between the onset of the stroke and his arrival at Ipswich hospital was about 4 hours.

8. The stroke has left the claimant with what is classed as a "Rankin scale 3" moderate disability. This means he requires help but can walk without assistance (he uses a stick). However, there has been a significant impact on his life; his ability to work and his domestic independence. The claimant is also now unable to pursue his interest in the outdoors, or in motorbikes. He now spends much of his time in the house. He is embarrassed by his disabilities. His claim is that had he been taken to hospital earlier, and had thrombolytic treatment, then he would have had a real chance of achieving a better result at 0-2 or better on the Rankin scale; a better medical outcome would have been achieved and the worst effects of the stroke would have been mitigated.

9. The claimant does not remember very much of what happened to him apart from isolated snap-shots. He accepts that his recollection is muddled and vague. He has some recollection of being stopped by the police, arriving at the PIC, seeing the FME and arriving at the hospital. He remembers trying to speak but being unable to do so and being unable to think clearly or process what was wrong. He has no recollection of being asked any questions. He confirms, and I accept, that he would have taken thrombolytic treatment had he arrived at the hospital within the appropriate treatment window and been advised to do so.

The Claims

10. The Claimant brings a claim for declarations and damages under the Human Rights Act 1998 ("HRA 1998"), alleging that the First and Second Defendants, as public authorities, acted in violation of Articles 3 and/or 8 of the European Convention on Human Rights ("ECHR"). Claims in negligence and false imprisonment have been

abandoned. On the balance of probabilities, early medical attention would not have yielded a better result for this claimant.

11. The first defendant ("the Chief Constable") is responsible for all the operational activities of Suffolk Police and the officers performing police functions. The second defendant ("G4S") is a company to which the provision of medical services for the Chief Constable (including the assessment of the condition of those detained at police stations) has been out-sourced.

12. Article 3 of the ECHR provides: *"No-one shall be subjected to torture or to inhuman or degrading treatment or punishment"*.

13. Article 8 of the ECHR provides:

    1.Everyone has the right to respect for his private and family life, his home and his correspondence.

    2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

At The Police Investigation Centre ("PIC")

14. On arrival at the PIC the claimant was presented to the custody sergeant, Sergeant Ramsey, who opened a custody record ("CR") at 2.47am.

15. PC Jackaman said that during the booking-in procedure the claimant was unsteady on his feet and during the subsequent drug testing procedure he was "*unable to speak or communicate and could not answer the relevant questions*". He amplified his written evidence by confirming that from his viewpoint the claimant was unable to give his name or to produce any speech, he was struggling to talk, was unsteady on his feet, unable to get his shoes off and unable to sign documents. PC Jackaman did not describe these problems as a refusal to speak on the claimant's part. During a prolonged wait in the intoximeter room the claimant urinated on himself but was unable to communicate this. Despite this, and what PC Jackaman accepted was "*strange behaviour*" and "*obvious signs of agitation*" (compared with PS Ramsey's conclusion that the claimant was not agitated), he did not consider that this rang any alarm bells. He said that he had formed the view that the claimant was intoxicated by drugs and had no reason to alter his conclusion. He appreciated that it was essential to guard against assumptions but had reached the "*firm belief*" that the claimant's behaviour, and in particular his lack of speech, was the result of taking drugs and not due to some underlying medical event or emergency. PC Jackaman did not notice any drooping or asymmetry of the claimant's mouth at any stage. He said he had no suspicion that the cause of the claimant's problems was other than drug related. Far from that being "*spectacularly incurious*" (as was put to him) it reflected no more

than what he had seen with other drug-driving detainees in the past. He accepted the need to reflect on and reconsider his firm beliefs but saw nothing that he thought justified any reassessment. It was only in hindsight the following day when he learnt what had happened to the claimant that he considered he had any reason to doubt his conclusion.

16. PC Jackaman's firm belief was based on his assessment that the claimant had been able to stop his car when required by police to do so; his ability to understand and respond to instructions regarding exiting the car (with help) and take the roadside breath test (albeit with gentle breathing) together with his apparent ability (despite his silence) to understand the procedure at the booking-in procedure and respond to instructions then given to him. He saw no sign of facial palsy despite being with the claimant for an extended period of time. These factors, when taken in the context of PC Jackaman's evidence to the effect that he had experienced other detained drink drivers behave with a degree of unsteadiness and agitation, did not cause him to reconsider his belief as to the cause of the claimant's presentation. That cause, to his way of thinking, was some unknown substance the claimant had taken.

17. PC Hassall took over what was PC Jackaman's case in the intoximeter room at about 3.30am. He was given a brief overview of the claimant's case by PC Jackaman. PC Hassall's main job was to wait with the claimant until the doctor arrived. In the nearly 2 hours before the doctor eventually arrived he was not aware of the claimant suffering any facial droop. He did not notice any shaking. He tried to engage the claimant in conversation and formed the impression that the claimant was trying to speak but was unable to and was presenting as being generally exasperated. He noted particularly, however, that when the doctor arrived the claimant was able to walk unaided to the medical assessment room. He thought overall that the claimant was either unwilling or unable to communicate but that monitoring the claimant's condition was the responsibility of the custody sergeant. He was not aware of any Guidance.

18. PC Jones (whose evidence was taken as read) was with PC Hassall and his evidence is to similar effect. "*There was nothing in his* [the claimant's] *manner that stood out and it appeared he simply did not want to talk*". He says that he has often worked with PS Ramsey and had there been anything strikingly obvious about the claimant's condition he would have had no hesitation in mentioning it. PC Jones recalls the doctor [Dr. Klotins] saying something to the effect that had he been told on the phone of the claimant's symptoms he would have advised hospital admission as soon as possible. Dr. Klotins recalled that he had said something of the sort after the claimant had been despatched to hospital and that he had said this to make a learning point for the police officers.

19. PS Ramsey was the custody sergeant. The PIC was busy on the night of the 18 May 2014. He authorised the detention of the claimant at 2.49am for the purposes of the station intoximeter procedure. PS Ramsey's impression was that the claimant was very withdrawn, depressed and uncommunicative. The claimant's identity was

obtained through a PNC check on the car and further checks were done on the CIS system which contained information relevant to the claimant's background. PS Ramsey's impression was that the claimant was refusing (as distinct from unable) to supply his personal details, but that the claimant understood what was happening and communicated by nodding and using eye contact. He thought the claimant was depressed and that his behaviour was consistent with someone who was "*utterly despondent*". The claimant was booked-in for a station breath test. No risk assessment was carried out because as the CR records the claimant was "*Not speaking*". PC Ramsey accepted that the lack of a risk assessment was itself an indicator of increased risk for a detainee.

20. In due course, and certainly by the time the sergeant visited the intoximeter room where the claimant was waiting for a doctor, the sergeant was in possession of the information obtained from the CIS system. This confirmed the sergeant's impression that the claimant had cause to be despondent due to a number of recent, serious reverses in his personal life; including reports of self-harm and homelessness.

21. PS Ramsey accepted that when booking-in he was told by PC Jackaman that the claimant "*was not comprehending what I'm saying*" and that he was "*actually struggling to talk*". He also accepts that later, in the intoximeter room, he was told that the claimant was "*unable to speak*" and "*unable to open his mouth*" and "*struggling to understand*". The claimant did not appear to PS Ramsey to be agitated in any way.

22. The sergeant was clear in his oral evidence that had he considered the claimant to be incapable he "*would have gone straight to the 999 system*". In other words, he would have short-circuited all other procedures and either called an ambulance or arranged for the transfer of the claimant to the hospital only 10 minutes' drive away from the PIC. He said: "*I did not think it was an incapacity case*". He said: "*I did not consider it a medical event. If I had thought* [the claimant] *was incapable for any reason, I would have called for urgent medical assessment*". "*I was being observant but saw no* [facial] *droop*". The sergeant's conclusion was threefold. First, that the claimant's presentation was the result of drug use. Secondly, his despondency, given the CIS information, was likely to be caused by his arrest in the context of his recent, adverse life events and could be complicated by mental health issues. Thirdly, the claimant was refusing to speak and PC Jackaman's resort to expressions of the claimant being incapable of speech were just "*turns of phrase*".

23. PS Ramsey also accepted that he did not discuss with PC Jackaman at any stage the discrepancy between PC Jackaman's language indicating possible incapacity and his own personal assessment of the claimant's presentation. That assessment was to the effect that the claimant was refusing to speak (not incapable of speaking).

24. Neither PS Ramsey nor PC Jackaman believed the cause of the claimant's presentation was anything other than drug-related and/or despondency. PS Ramsey construed it as the claimant refusing to speak; PC Jackaman a drug-related inability to speak. Neither considered that the claimant presented as an actual or potential medical

emergency. Both accepted that the apparent effect of drugs on a detainee could mask an alternative or underlying medical problem. Neither thought that was the case here, despite the fact that the claimant had a problem signing his name; was to an extent unsteady on his feet at booking-in and had difficulty with his shoes and shoe laces; later urinated on himself in the intoximeter room and did not speak at any point during his time at the desk or in the intoximeter room. PCs Hassall and Jones noticed nothing they considered potentially medically untoward either.

25. The CR includes the following entries. At 2.53am it is noted that the claimant was not informed of his rights because he was "*incapable of understanding what is said*". (PS Ramsey was uncertain if this is free text or a drop-down choice but inclined to the latter). At 2.56am the claimant was "*incapable*" of signing the Record of property because "*Does not appea* (*sic*) *to understand*". (This is likely to be free text due to the spelling mistake). Later at 2.59am it is recorded "*DP calm but refused to speak at all"; "DP did not engage with any questions but appeared to understand*". The CR also reveals that the claimant was placed in a cell under constant supervision at 4.40am due to the delay in the doctor arriving and "*due to his continued lack of interaction and engagement*". However, at 5.11am and 5.34 the claimant was roused by PC Sheeran and responded verbally although he still appeared "*not alert*" and "*under the influence of a substance*".

26. The booking-in procedure and the events in the intoximeter room are captured on good quality CCTV footage. The footage reveals something of a mixed picture but in my judgment does not show much that is likely to have given the lay observer anything substantial to be medically concerned about regarding the claimant's condition.

27. With the benefit of hindsight the apparent problem the claimant had with his shoes (and the nursing of his right hand and arm in the process) and holding a pen, seen on the CCTV footage at the reception desk, are potentially worrying. Similarly troubling is the fact that the claimant urinated on himself (a little) whilst in the intoximeter room without being able to communicate this to PC Jackaman.

28. However, when the events are looked at as a whole, these comparatively isolated episodes of potential concern take on a different perspective. When offered the chance to visit the toilet by PC Jackaman the claimant responds positively, steadily and in a sure-footed manner with purposeful strides. He also walked unaided to the medical assessment room when the doctor arrived. He is able to respond to instructions to be seated. The claimant has his head in his hands and sits backwards and forwards in his chair (both at booking-in and in the intoximeter room), standing up from time to time. When seated he is not floppy, swaying from side to side or apparently unresponsive or for the most part physically stiff or showing signs of weakness in his arms or legs. When searched, he takes a step back which could be construed as unsteadiness. The claimant's condition did not visibly deteriorate at any time during his detention at the roadside or at the PIC. Neither did it improve, save to the extent that PC Sheeran

records in the CR a verbal response from the claimant when rousing him on two occasions. In my judgment, none of this appears to be particularly dramatic and is consistent with PS Ramsey's assessment that the police were dealing with a detainee who was refusing to speak (rather than incapable of speech), whose attitude was the result of drug-taking and despondency in the context of a number of negative life-events.

29. In all probability the facial drooping experienced by the claimant (observed by the FME Dr. Klotins) either occurred shortly before the doctor arrived or was so subtle as to be indiscernible to a reasonably observant layman. It had been unobserved by the 4 officers (5 if one includes the rousing officer PC Sheeran) who had variously had the claimant under close observation for several hours. The claimant was not dribbling at any stage. Dr. Payne-James (FME expert instructed by the claimant) said that he would expect non-medical people to spot facial drooping but "*no one can say when the drooping would have become apparent*" and further that "*I do not believe that there can be a general expectation that a non-medically trained individual to recognise the subtle signs of a stroke (even the speech component of FAST)"* (*Sic*) although he recognises that some might have greater awareness.

Contacting G4S

30. PC Last telephoned G4S at 3.04am. The purpose of the call was to secure the attendance of a doctor to administer a section 4 examination and drug test. G4S had earlier been called at 1.30am in respect of another detainee but no HCP or FME had arrived. The 3.04am call was the first and most important call in the sequence relevant to the claimant. There were three follow-up calls at 3.30am; 4.32am and 4.49am.

31. At 3.04am PC Last speaks to Gemma by telephone. Extracts from the transcript of the conversation include the following:

    PC: "We need a doctor don't we"
    Gemma: "If it's down to drugs then Yes"
    PC: "He's not verbally engaging whatsoever … we still … need to follow it up with an unfit assessment…"
    Gemma: "…absolutely yea … any health conditions that we are aware of?"
    PC: "He won't engage verbally"
    Gemma: "…the he's not known to you, you don't recognise him or anything?"
    PC: "…we know who he is …"
    Gemma: "Ah fine, so nothing that's … been (brought) up"
    PC: "No".
    Gemma: "Right OK … my colleague just got Dr. Klotins on route, he's travelling from …quite far away." [The doctor is likely to exceed the one hour target].

    At 4.32am it is likely that it was PS Ramsey ("Mark") who called the G4S call handler (although he does not remember it) asking for an estimated time of arrival for the medic attending for the claimant's section 4 tests. The operator could not reach the doctor and promised to call back as soon as she got hold of him. There was no call

back. At 4.49am PS Ramsey tries again (and again he does not recall making contact). This time he was informed that the doctor was about 15 or 20 minutes away. By the time Sergeant Holly Branch called G4S from Martlesham to complain about delays later that morning, there were 5 other detainees waiting for an HCP at the PIC.

Dr. Klotins (the FME).

32. Dr. Klotins arrived at the PIC at 5.19am. He carried out a medical assessment of the claimant starting between 5.40am and 5.44am. He does not recall where he was when he first received a call to attend the Martlesham PIC. He does not recall whether the G4S operator informed him that the claimant was not engaging. So far as he was concerned he was attending a section 4 call-out. No medical concern had been reported to him about the claimant's condition.

33. When he arrived at the PIC he was told that the claimant had been detained on suspicion of drug related driving and was someone who had mental health difficulties. He noted: "*DP was unable to communicate verbally with me during the examination. I believe this is due to neurological impairment. He appeared to understand what I said and denied any drug use.*" It is apparent from this that there was some level of communication and an apparent understanding on the part of the claimant as to what was happening.

34. In more detail on meeting the claimant, Dr. Klotins says: "*it soon became apparent to me that he had suffered some sort of stroke or TIA and that he immediately needed to be transferred to hospital. I immediately spoke with officers to arrange an ambulance or police car…*" What led to this conclusion was that the claimant was trying, but unable to speak; he was "*slightly*" rigid and asymmetrical in his movements and his face was asymmetrical. Dr. Klotins also says: "*I can also see why …* [the police] *did not suspect something more alarming. The features which I recognised were not immediately apparent and were relatively subtle*". He says that the facial asymmetry was more apparent when the claimant was trying to speak. The doctor recalls saying to one of the police officers (probably PC Jones) that had he been told about the features he recognised as a stroke or ITA on the phone he would have told the police to send the claimant to A&E. However, this "*learning point*" as Dr. Klotins described it can only be helpful if the not immediately apparent and subtle signs were such that a reasonably observant layman could still be expected to notice them.

35. In his oral evidence Dr. Klotins confirmed what he saw of the claimant's presentation. He said: *"My initial impression was not that he was unable to speak but that for reasons of his own was choosing not to speak". "My impression was that that he was understanding what was being said because he was nodding".* The fact that the claimant had to be referred to hospital came as a shock to Dr. Klotins, it being the only occasion in his 8 years as an FME that he encountered the need for a hospital referral on a section 4 call-out.

36. Dr. Klotins also notes in his evidence that G4S provided a 24/7 telephone advice service which could be used by the police at any time if they wanted to speak to a

medic. In oral evidence, Dr. Payne-James's reaction was one of surprise when this was drawn to his attention.

Conclusions from the roadside and PIC

37. PC Jackaman and PS Ramsey (and to a lesser extent PCs Hassall and implicitly Jones) have been challenged on the basis that they were unobservant and, having started with the assumption that the claimant was intoxicated and despondent, unthinkingly proceeded to treat him as such for the entire period of the claimant's detention without ever re-evaluating troublesome features of his presentation that were there to be seen, or, pausing to reflect and reconsider their assumption. At the centre of the challenge is the use of the language of incapacity in the documents and the exchanges between particularly PC Jackaman and PS Ramsey. At the very least, it is submitted, there was sufficient cause for doubt regarding the claimant's speech to trigger a request at or about 3.00am for urgent medical assistance or immediate referral to the nearby hospital.

38. I reject those criticisms. It is evident, with the benefit of hindsight, that the police officers at the roadside and at the PIC missed the fact that the claimant had had a stroke. However, looked at objectively at the time, the observable features of a stroke were subtle. Dr. Klotins' evidence to this effect is supported by the FME experts who in their first Joint Statement state that "*…to a doctor the lack of speech was a subtle sign of stroke*" and "*We are of the opinion that he* [the claimant] *was not displaying the classic stroke symptoms…*" "*The speech problems were signs of a stroke and whilst they might be obvious to a* <u>*doctor*</u> *we would not necessarily expect a lay person or* <u>*other healthcare professional*</u> [emphasis added] *to recognise them".*

39. I accept the evidence of PC Jackaman as to the circumstances that caused him to stop and breathalyse the claimant at the roadside. His initial suspicion that the claimant was intoxicated through drink was reasonable. When the roadside test was negative it was reasonable to suspect that the cause of the erratic driving was drugs-related. In so far as it is within their remit to do so, the FME experts confirm as much in their first Joint Statement. I accept PC Jackaman's evidence that he had no concerns about a medical emergency at any time before he arrived at the PIC with the claimant, nor when the claimant was being booked-in by PS Ramsey.

40. Although not speaking and with shiny phlegm around his mouth, the claimant had complied with instructions to stop his car and did so appropriately; he had understood and complied with roadside breathalyser instructions, with assistance he was able to get out of his car and was able to walk to the police car as directed. There were no visible signs of difficulty with his arms or legs at the roadside. There was, I find, no or no discernible facial drooping.

41. Despite some elements of strange behaviour at the PIC desk (including an apparent inability to produce any speech) PC Jackaman continued to hold to the belief that he was dealing with a drug-driving case. His belief was reasonable in all the

circumstances in my judgment. Such signs of agitation as PC Jackaman accepted the claimant displayed were intermittent and modest. The CCTV does not show the claimant being in an agitated state, and certainly no more agitated than would be expected of a driver in custody anticipating further evaluation for drugs use.

42. During the period before PC Jackaman handed over to PC Hassell in the intoximeter room (between 3.05am and 3.30am) he does not recall reconsidering what he described as his firm belief. I accept that he was aware of the dangers of making assumptions, but from what he saw of the claimant in the intoximeter room (which included the claimant urinating on himself and then being taken to and using the toilet) he did not consider an alternative to this belief. He said "*I did not think anything else was going on*". In my judgment PC Jackaman's continuing belief (covering the period in the intoximeter room) was reasonable. By this time PS Ramsey was in overall supervisory charge of the claimant.

43. I accept the evidence of PS Ramsey to the effect that he had been observant of the claimant throughout his dealings with him. So much is apparent from the CCTV at the reception desk and at the point where PS Ramsey first enters the intoximeter room and crouches down face-to-face with the seated claimant. I accept his evidence that he considered at the time that his assessment of the claimant had to be a dynamic process and needed to be kept under review. I accept that he remained open-minded. This is illustrated by the fact that PS Ramsey's visit to the intoximeter room was brought about by information obtained from the CIS system about the claimant's personal problems which triggered concerns, in the context of his presentation, about the claimant's mental health. It was continued mental health concerns that caused PS Ramsey to upgrade the level of observation on the claimant at 4.40am as noted on the CR "*…now placed in cell under constant supervision due to his continued lack of interaction and engagement*". This, I accept, was done due to PS Ramsey's concerns of suicide risk. PS Ramsey was aware of and applied the FAST mnemonic and was aware that someone seemingly affected by drugs could instead be suffering from a medical problem. He accepted that had he thought the claimant was *incapable* for any reason he would have called for an urgent medical assessment.

44. The claimant presented to PS Ramsey as withdrawn and vulnerable. However, taking all the circumstances into account, as carefully assessed by him at the time, in my judgment he reasonably considered that he was dealing with a drugs and mental health case and specifically excluded any possible medical emergency. He expressed his conclusions in this way. "*I thought drugs or suicide; not medical. I did not see stroke. I did not see incapacity ... I am thinking mental health. That was my assessment*". I accept his evidence that this was a positive, considered conclusion at the time of the booking-in procedure; in the intoximeter room and at the time the claimant was moved to constant observations. It is only with the benefit of hindsight that PS Ramsey's judgment can be characterised as a misjudgment.

45. The entries in the CR that use the language of incapacity and understanding have to be seen in the light of the evidence from PS Ramsey that I have accepted. I am not

satisfied that those entries reflect anything more than an imprecise use of language by a custody sergeant in a busy PIC.

Guidance for the Care of Detainees

46. Guidance on the Safer Detention and Handling of Persons in Police Custody (second edition) was promulgated by the Association of Chief Police Officers in March 2012. This was decommissioned in October 2012 and superseded by Authorised Professional Practice ("APP") published on-line under the auspices of the College of Policing. The relevant content of the applicable APP is derived from the evidence and Report (3 August 2017) of Dr. Payne-James. All police custody staff and healthcare professionals working with detainees should be be familiar with APP guidance. From the Guidance applicable in May 2014 the following points are of particular interest.

    46.1 Detainees requiring urgent medical attention should not be taken to a police station. Detainees suspected of swallowing unknown quantities of drugs should be taken to hospital immediately.

    46.2 All detainees believed to be under the influence of drugs should be medically assessed by a healthcare professional. An HCP should also be consulted where any detainee is assessed as requiring constant observation.

    46.3 Particular symptoms and behaviours are identified as demanding particular attention; including any problems understanding or speaking.

    46.4 A detainee's unwillingness or inability to participate in a risk assessment should be seen as an additional risk factor.

47. Annex H to Code C of the Police and Criminal Evidence Act 1984 Codes of Practice cautions against the risk that a detainee's presentation for alcohol or drug-related problems may mask an underlying health condition of which a stroke is a specified example. Annex H also says that an appropriate HCP or an ambulance must be called where a detainee cannot answer questions such as "What's your name?" or "Where do you live?".

48. There is also guidance to the effect that *"when there is any doubt, police should always act urgently to call an appropriate healthcare professional or an ambulance"* and "*...remember that any…incapable detainee is a medical emergency until proved otherwise."* (Code C Detention etc.).

49. PS Ramsey, PC Jackaman and the other officers on duty at the PIC did not, in my judgment, fail to heed applicable Guidelines. At the time they reasonably considered that there was no room for doubt.

50. PC Jackaman and PS Ramsey independently concluded on objective grounds that the claimant was not presenting as being in need of immediate or urgent medical attention. PS Ramsey remained open-minded about the claimant's presentation and reasonably concluded that the claimant was not at any stage in need of medical attention over and above the medical assessment required under the RTA section 4.

PC Jackaman reasonably considered that there were no grounds to alter his firm belief in the reasons underlying the claimant's lack of verbal communication. Both were conscious of the possible masking effects of drugs and the potential for illness to mimic the effect of drugs. Both were aware of the FAST mnemonic. PS Ramsey had personal, family experience of stroke and the visible signs of stroke. The claimant was reasonably believed to be affected by drugs and medical assessment was sought for him at 3.04am when PC Last called the G4S call centre. The request for a section 4 assessment necessarily includes a medical assessment, which must be by a doctor, to determine whether there are drug-related grounds for proceeding with the section 4 forensic tests.

51. The APP Guidance must import an element of assessment and judgment on objective grounds. The "*swallowing of unknown quantities of drugs*" can only sensibly be construed as a reference to a detainee attempting to dispose of or hide unknown quantities of drugs by swallowing them, otherwise any drug-taker or suspected drug-taker would have to be taken immediately to hospital because the amount of drugs ingested would be always be unknown. This claimant, being believed to be under the *influence* of drugs, and being ultimately placed on constant observation, *was* to be medically assessed. That assessment was necessarily implicit in the request for an FME to do a section 4 assessment. The section 4 medical assessment would uncover any masked underlying health condition (Annex H of Code C). This is exactly what happened in the present case. No doubt decisions made by the police about hospital admission and drug-related medical assessment are informed by context and all the circumstances. Special attention in context must be given to any apparent problems with understanding and speaking as well as the absence of a risk assessment. PS Ramsey, who was ultimately the officer responsible at the police station, was careful in his continuous assessment of the claimant and arranged for a section 4 assessment having made a reasonable judgment about the reasons underlying the claimant's presentation, including his lack of verbal communication and the absence of a risk assessment. In my judgment no breach of applicable Guidance has been established in this case.

52. At no stage at the roadside or at the PIC did any of the police officers know the claimant was presenting as a stroke victim or as any sort of medical emergency, nor were there grounds on which they reasonably ought to have known or foreseen that he might potentially become an emergency case. In all the circumstances there were no grounds on which any of the police officers ought to have known or foreseen that the claimant presented as one at risk of Article 3 ill treatment or at any stage as someone other than a suspected drug-driver. Signs of stroke were subtle even by the time Dr. Klotins examined the claimant. The signs were so subtle that even a healthcare professional other than a doctor would not be expected to notice them, much less, I conclude, a police officer or other layman.

53. It is not surprising, therefore, that when Gemma at G4S was contacted by telephone the information supplied by PC Last was as it was. In any event, the result of the call

was that a doctor was despatched although his expected time of arrival was likely to be beyond the one-hour contractual target.

The G4S System

54. From the evidence of Jonathan Scott and the documents it appears that when the police at a PIC assess that medical attention for a detainee is required, or forensic tests are needed, a telephone call is made to the G4S call centre in Essex. The call centre is staffed by between 3 and 5 call handlers (or call managers) who take the in-coming calls. The call handlers are trained but are not medically qualified. The Chief Constable has no in-put into the content or delivery of the training. The first call-handler on 18 May 2014 was Gemma who was herself a trainer. Gemma has not been called as a witness in this trial. There is a team leader or assistant team leader on duty at every shift and a duty "shadower" on call all the time if staff at the call centre need more help. Call handlers have access to the on-duty doctor at any time should they feel it helpful to consult a doctor. All the call handlers on duty work from a single work station comprising 6 desks on which there is a ring binder containing the training manual, flow charts designed to illustrate alternative courses of action to be taken depending on the nature of the enquiry, and a set of flashcards designed to prompt the call handler to ask appropriate questions. These documents were designed by G4S's senior clinicians. The call handlers' objective is to capture information provided by the caller, assisted where necessary by the documents at their disposal, to prioritise call-outs and to allocate call-outs to an appropriate HCP or FME. Medical calls have priority over forensic calls. Mr. Scott accepted that in capturing information from the caller there should be an element of "teasing it out". The flashcards are intended to help with this.

55. The document relied on by Mr. Scott and exhibited to his witness statement is a tender questionnaire dated 8 December 2014 (after the events with which I am concerned) but Mr. Scott was confident that principles set out in the tender properly reflect what was expected of G4S in May 2014 in Suffolk. All call handlers undergo 30 days training and in order to complete the training must demonstrate an understanding of clinical protocols, geographical areas and operations and logistics. As for call prioritisation:

    "*Call requests are prioritised in order of the patient's clinical need – first and foremost we ensure that the service being delivered is safe. In order to establish a patient's clinical need an initial triage will be undertaken by the call manager [handler]. This will identify the reason for the request including any acute conditions which need addressing …. Where the call manager feels there is a danger to the patient the call will be transferred to a Doctor for immediate advice*".

56. I am satisfied on the balance of probabilities that the flashcards (including the "RTA 4 Drug Drive" card) exhibited to Mr. Scott's witness statement were current and in use on 18 May 2014. This is more likely than not given that changes were made in 2015 (for example to the RTA section 5 card) that are not reflected in his exhibited examples.

Such a conclusion is most likely given Mr. Scott's personal experience of monitoring many calls. He knows that flashcards of some sort were in use in May 2014. He is not aware of any others. The likelihood is that they were the ones exhibited.

57. G4S also make available a 24hour telephone advice service by which the police may call a doctor for advice directly, or to which the police can be referred by call handlers at the call centre if the circumstances demand.

58. Call-outs from the police include cases where a "section 4" forensic test is sought to test whether a detainee has been driving under the influence of drugs; that is, where the detainee is suspected of committing an offence pursuant to section 4 of the Road Traffic Act 1988. Section 4 testing involves 2 stages. First, a medical assessment as to whether there is a proper basis for the suspicion and secondly, if there are such grounds, to take a blood sample. In May 2014, section 4 assessment and testing, had to be undertaken by a doctor; a forensic medical examiner ("FME").

59. A request for a section 4 call-out is not regarded as a medical emergency. In 2014 there should have been two healthcare professionals ("HCPs") available on-call to cover Suffolk alone, one for each of the 2 PICs (one of which was Martlesham) and one FME available on-call to cover both Suffolk and Essex for any given shift. On the 18 May 2014 the HCP allocated to cover Martlesham was absent due to sickness. It is not known why, or when this sickness absence became known, save that it was at some time during the shift. The FME that night was Dr. Klotins who was based at the custody suite at Harlow in Essex. HCPs are able to deal with most medical call-outs. However, with one off sick, it might be assumed that the workload on the other HCP (based at Bury St Edmunds) and the single FME would be increased. As a result, it is possible that the response time of the FME to individual call-outs was longer than it would otherwise have been. At that time no more than 5% of call-outs required a doctor, but in May 2014 an FME actually attended at Martlesham PIC in answer to nearly 25% of call-outs. G4S were contractually required to respond to 90% of call-outs within 60 minutes. Financial penalties applied if the 10% tolerance was exceeded. 60 minutes was measured from the receipt of the call to the time the medic arrives at the relevant PIC. Arrival at a PIC even one minute after the target time counts as part of the 10% tolerance.

60. What is known about G4S staffing specifically on 18 May 2014 also comes from the evidence of G4S's head of operations Jonathan Scott. This is second-hand information because Mr. Scott had nothing to do with the events of that night and only joined G4S in October 2015. The activity log reveals that at 1.24am the FME was called to Braintree to deal with a dog bite. Martlesham PIC first called out a medic at 1.48am in respect of a detainee withdrawing from drug dependency (not the claimant). This call could have been attended by an HCP had one been available. It is probable that at 1.48am the FME was already on his way to Braintree. The precise whereabouts of Dr. Klotins at the time G4S were first called out for the claimant at 3.04am is unknown. He does not recall this himself. It is approximately 70 miles from Braintree to Martlesham and about 40 miles from Harlow to Martlesham.

61. Paul Loveday is a Custody Development Officer and was so employed by Norfolk and Suffolk Constabulary in 2014. As a witness he dealt with what Suffolk police expected of the contract specification used by G4S in May 2014 and what from the police perspective the contract was supposed to deliver. Perhaps Mr. Loveday was not the ideal person to deal with such issues although he was clearly well informed about the relationship between police forces across the country; the NHS and the contracting-out process as it has evolved over the years. I found his evidence to be confusing and, in the end, not very helpful. There were potentially important discrepancies between his written statement (17.08.17) and his oral evidence. I took him to be saying that he did not, from the police perspective, expect call handlers to be clinically trained and that call handlers would prioritise call-outs on the strength of the information provided to them by police officers and elicited by call handlers, subject to both police and call handlers having access to a medic by telephone 24 hours a day. However, he also agreed that he was not happy with non-clinically trained call handlers because a patient's health needs might not be readily understood or acted upon and that the use of a clinician at this telephone triage stage was the only safe way to identify "*those cases*". He agreed that the transcript of PC Last's call at 3.04am caused him some concern on the basis that "*we expect the provider* [G4S] *to elicit the information*". I got the distinct impression that Mr. Loveday was suggestible and open to agreeing with whatever he was asked, particularly if any valid criticism could be deflected onto G4S.

G4S – A Public Authority

62. Article 3 and 8 duties apply to public authorities as defined by section 6 and 6(3)(b) and (5) of the Human Rights Act 1998 "*…it is unlawful for a public authority to act in a way which is incompatible with a Convention right ...*" A public authority includes … *"(b) any person certain of whose functions are functions of a public nature*". By subsection (5) "*In relation to a particular act, a person is not a public authority by virtue only of subsection (3)(b) if the nature of the act is private*." It is accepted that the duties apply to the Chief Constable as a public authority. There remains an issue whether G4S is a public authority for the purposes of this action although the point was not pressed with any enthusiasm in closing submissions by Counsel for G4S.

63. There is a distinction between "core authorities", the conventional expression used to describe bodies that are public authorities for all purposes, and so-called "hybrid authorities", an authority that exercises both private and public functions. Where the acts of a hybrid authority are in issue the relevant question is whether the nature of the act is private. As Elias LJ said in *R (Weaver) v London & Quadrant Housing Trust* [2010] 1 WLR 363 at 370 [28] *"... once it is determined that the body concerned is a hybrid authority – in other words that it exercises functions at least some of which are of a public nature – the only relevant question is whether the act in question is a private act".* Elias LJ from [35] summarises the principles capable of being drawn from earlier authorities. Those principles include the purpose of section 6 of the HRA being to identify those bodies which are carrying out functions which will engage the

responsibility of the UK before the ECtHR; the adoption of a factor-based approach to determining whether a body is a public authority and a generous approach to section 6(3)(b). Other factors such as public funding, the exercise of statutory powers, whether a body is doing the work of the government or a local authority and whether it is providing a public service. I do not detect any hierarchy of factors in the earlier cases and no doubt differences of emphasis arise in the particular circumstances of any given case.

64. G4S submits that it is a private company carrying out private functions including the acts of medical assessments and forensic testing that are private in nature. It should not be regarded as publicly funded or subsidised simply because it entered into a commercial contract for the provision of medical services with the police.

65. It is submitted on behalf of the claimant that G4S provide the means by which the state (the police) purports to fulfil its general duty to the public under Article 3 and the provision of an FME is a function that has crucial public attributes.

66. In my judgment G4S is a "hybrid" authority and falls within the scope of section 6(3)(b) of the HRA; it is an authority that exercises both private and public functions. The function in this case is the function of providing medical services to the police, in particular within that broader function the function of providing HCP and FME services for the benefit of police detainees. The function of G4S is to provide healthcare services and materials to enable the Chief Constable to comply with the statutory responsibility to ensure that detainees have access to appropriate healthcare while in custody, which should be provided in a timely and effective manner. The only document in evidence that deals with how this function is to be achieved is the *Suffolk Police Authority Tender for the Provision of Forensic Medical Examination Services (Tender Reference C516)* together with the incorporated *General Terms and Conditions of Contract for the Supply of Services.*

67. As one would expect, the tender requirements are detailed and comprehensive. They demand compliance with a range of statutory standards and guidance, involving wide-ranging and intrusive statutory powers affecting the integrity of detained individuals, covering amongst many other things the quality, qualifications and experience of medical staff; the handling of medicines; clinical auditing; the quality of medical equipment, as well as internal staffing and governance requirements. The tender documents require coverage of mental in addition to physical well-being; compliance with all equality legislation and good practice. The collection and provision of forensic samples for analysis and the availability of personnel for evidential purposes are also important general demands of the tender.

68. The arrangements the Chief Constable has with G4S, based on the tender documents, reflect the delegation or out-sourcing of vital public services. This delegation does not absolve the Chief Constable from liabilities that might otherwise arise and is not conclusive in determining whether, in this context, G4S's function is that of a public body. However, in my judgment, the contractual assumption of responsibility for the

delivery of such significant public services to a vulnerable section of the community (i.e. detainees) is strongly indicative of the public nature of the role G4S has assumed. When one adds to this the fact that any contract between G4S and the Chief Constable will be publicly funded (in the sense that this function of a public nature is effectively subsidised in part or as a whole from the public purse) the function undertaken by G4S relevant to this case are sufficient to identify G4S, in context, as a body or authority carrying out a public function. As G4S has many other commercial roles, it is a "hybrid authority".

69. In order to determine whether the claimant's Human Rights are engaged with G4S it is then necessary to consider whether any relevant act of G4S was a private act (section 6(5)) taking it outside the provisions of section 6(3)(b).

70. In my judgment none of the relevant acts at issue in the present case were private acts. The relevant acts include the provision of an adequate triage system and providing a contractually timely response to a call-out. Each of these is so intricately intertwined with the public function that it is unrealistic to regard them as private acts within a public framework. G4S is, therefore, a public authority for the purposes of Articles 3 and 8 in the present case.

The Claimant's Claims in Context

71. The first feature of Article 3 relevant to this case is that it imposes a positive general duty (a "systems" duty) to secure the health and well-being of those in detention by means of having proper systems in place to prevent breaches. This general duty requires that legislative and administrative systems are put in place which will make for effective prevention of the risk to the health and well-being of those under the control of public authorities. The focus of this part of the action has been on G4S, but the Chief Constable also remains ultimately responsible. There is no claim based on any failure on the part of the Chief Constable to monitor the system devised by G4S.

72. The claimant's case is that the system as out-sourced to and designed by G4S was demonstrably inadequate. It was inadequate because the geographical area covered by FMEs and HCPs was too large to allow for appropriate response times; it was not robust enough to deal with occasions where staff were off sick; the triage process was not manned by or overseen by a clinician and the information available to assist unqualified call-handlers, for example, on flash-cards was too limited (and did not cover the risk of a detainee suffering a stroke). In more detail, as derived from the Re-Amended Particulars of Claim:

72.1 The contractual arrangements with G4S made no proper provision for prioritising calls, response times or recommendations for alternative means of treatment such as hospitalisation (triage concerns).

72.2 The arrangements with G4S made no proper provision for ensuring that relevant information was obtained by G4S call handlers about a detainee's current condition. In particular a clinician should have been available to take calls, or at least to be readily available to call handlers in potentially urgent cases with an

appropriate protocol on which call handlers were trained to identify such urgent cases (enquiries concerns).

72.3 The contract with G4S permitted a geographical area for doctors (Essex and Norfolk) which created an obvious risk that the response time of 1 hour would be missed due to the distances it could reasonably be anticipated a doctor could have to travel (geographical concerns).

73. The second feature of Article 3 is that it imposes a positive operational duty owed to specific, identified individuals. In this second manifestation of the positive duty a claimant must establish that there was a real and immediate risk of Article 3 ill-treatment whereupon it is for the defendants to establish that reasonable steps were taken to address that risk. The standard demanded is one of reasonableness, but an operational duty must not be interpreted in a way that imposes impossible or disproportionate burdens on the authorities. The standard of reasonableness brings into consideration all the circumstances of the case including the ease or difficulty of taking precautions and the resources available. The focus of alleged operational violations has been on the Chief Constable.

74. It is alleged that the police missed any number of obvious signs in the Claimant's presentation from which they ought to have known that he needed immediate medical attention. The claimant was, it is submitted, known to be in "red flag territory" which equates to the police knowing that the claimant was at real and immediate risk of Article 3 ill- treatment yet his presentation was not assessed in any meaningful way for a period of about 3 hours and the chance of his getting the usual form of mitigating treatment for his stroke was lost.

75. On this operational basis, as against the Chief Constable, the claimant's case is that because strokes are potentially dangerous and the consequences are serious (all of which was or ought to have been known to the police officers dealing with the claimant) the claimant presented as someone who was at real and immediate risk of suffering adverse health and well-being consequences and the only reasonable response was to call for urgent medical advice and attention from a doctor or to call an ambulance or take him to the hospital, and keep their response continually under review.

76. As against G4S the claimant's operational case is that his presentation was not triaged adequately and that further questions should have been asked by the call handler (or the matter escalated by reference to a doctor). This aspect of the claim overlaps with the systems case focused on G4S.

77. The claimant's case is that had there been an adequate system in place and without the alleged operational shortcomings, he could have been expected to have reached a hospital between about 4.15am and 4.30am, two hours before he did get to hospital. Had he arrived at hospital at any time before 5.45am he would have received thrombolytic treatment and would have had a realistic chance of securing a greater level of recovery from his stroke than he has achieved.

78. In fact, from the neurology evidence, it is the "time to needle", as the neurologists put it, that matters. The agreed therapeutic window of 4½ hours from the onset of a stroke would not have closed until 6.55am on their agreed, estimated timings. The claimant arrived at the hospital by 6.30am, within the therapeutic window. However, it is to be expected that there would be some period of time between arrival at hospital and the "time to needle" to allow for triage and scans which the neurologists agree can be reasonably estimated as about 1 hour (admission) and 20 minutes (scans). Therefore, in order to achieve the "time to needle" by 6.55am the claimant would have to arrive at hospital by 5.35am. Had the claimant been treated as in need of urgent medical attention at 3.04am (the first call to G4S) or had Dr. Klotins arrived within the contractual hour (by 4.04am) the claimant would have received treatment within the therapeutic window (or outside it only to the extent of a few minutes such as is not likely to have prevented the thrombolytic treatment being offered).

79. In the Re-Amended Particulars of Claim it is alleged that the claimant was at all material times facing a real and immediate risk of Article 3 ill treatment and the police knew or ought to have known as much. With this actual or constructive knowledge, it is alleged, the police failed to take reasonable steps in response to the risk and acted pursuant to an unreasonable system.

80. The Re-Amended Particulars of Claim relies on allegations centred on the delay in the arrival of medical assistance and the failure to consider obvious, non-drug related causes of illness in that:

    80.1 The claimant was exhibiting extensive symptoms (of stroke) at the roadside and at the PIC.
    80.2 The unlikelihood that the claimant had taken drugs due to his personal profile (his age in particular) and the fact that his condition did not visibly improve whilst he was detained.
    80.3 No proper account was taken of any possible alternative cause for the claimant's symptoms, especially in the light of what should have been known about the symptoms of a stroke from published Guidance on stroke and on summoning medical assessment for detainees.
    80.4 The contractual target response time for medical assessment agreed with G4S had failed with regard to a call for a HCP for another detainee earlier on the same shift. An FME was unlikely to be available within the target timeframe of 1 hour from receipt of a request and as time passed during the night the increasing unlikelihood of timely medical assistance arriving increased.

81. It is common ground that a failure to provide appropriate medical care to a detainee may, in principle, constitute a violation of the operational duty imposed by Article 3. Where neither the conduct alleged, nor the withholding of medical care, is deliberate the claimant must establish that those responsible for his detention knew or ought to have known at the time that there was a real and immediate risk of the claimant being subjected to inhuman or degrading treatment. To be "real" the risk must be

substantial, and to be “immediate” it must be present and continuing. Authorities such as *R(MD) v Secretary of State for the Home Department* [2014] EWHC 2249 (Admin) and *Stoyan Mitev v Bulgaria* [App no: 60922/00] illustrate that delays in accessing medical treatment or an inadequate response to the medical needs of a detainee can engage Article 3 particularly where the potential impact on the detainee is serious.

82. To engage Article 3 at all the behaviour alleged to constitute the inhuman or degrading treatment must attain a minimum level of severity and must go beyond that which is considered reasonably coincidental to the fact of detention. It is not alleged in this case that there was any deliberate ill treatment of the claimant or a wilful refusal to call for medical assistance for him. The relevant behaviour here is alleged to be systems and operational failures either separately or in combination causing an unacceptable delay in the claimant’s treatment for a stroke.

83. The test as to whether the threshold of severity has been reached is objective and to be determined on the basis of all the circumstances including the gravity of the consequences or potential consequences of the alleged ill treatment on a person with the attributes of the victim. It is recognised in the present case that those attributes include the fact that the claimant was a detainee and as such vulnerable as well as the particularly grave potential damage that could be caused to him as a stroke victim in the event that he did not receive appropriate treatment in a timely fashion. Nonetheless, both defendants maintain that the treatment complained of in the present case does not reach the necessary threshold of severity necessary to engage Article 3.

84. I accept the Defendants’ submissions in this regard. I am not satisfied that the threshold minimum level of severity has been established in the present case. As I have found, the police officers had neither actual nor constructive knowledge that the claimant had had a stroke or was showing discernible signs of being at risk of medical deterioration or was otherwise in need of immediate medical attention. I do not accept that the police officers on duty at the PIC were even so much as incurious about the claimant’s presentation. Given the evidence of Dr. Klotins as to his own initial reaction to the claimant, and the agreed evidence of the FME experts about what a reasonable non-doctor might be expected to conclude, all that can be said is that the police officers’ inaction between about 3.04am and 5.19am has been shown with the benefit of hindsight to have been a non-negligent mistake.

85. In terms of suffering, with hindsight, it may appear that the claimant was at various points bewildered whilst he was in police custody. This, the police reasonably construed as the claimant being dejected and affected by drugs. Bewilderment, even when combined with a strong, subjective sense of isolation and abandonment (for what cannot have been more than about 2 hours during part of which the clamant was asleep) does not, in my judgment, objectively represent a high level of suffering even given the need for most stroke victims to be treated quickly.

86. The threshold requirement does not apply to Article 8.

87. The difficulty facing the claimant with his systems case against G4S comes from the agreed evidence of the FME experts: Professor Payne-James and Professor Wall. Their conclusions, culminating in their third joint statement of 19 February 2019, can be summarised in this way:

    87.1 There was no requirement for the call-handler (Gemma) to probe further behind the information she was given by PC Last at 3.04am or to make further enquiries.
    87.2 No particular investigatory protocol was required in the absence of any expressed concern by the police as to the claimant's medical presentation as described in the first call.
    87.3 The system that was in place was adequate and it was for the relevant custody officer to escalate the call to a doctor or transfer the claimant to hospital.
    87.4 Whilst the delay in the arrival of an FME would be of potential significance for the purposes of a non-urgent section 4 sample, given the information provided to G4S by the police, no emergency was apparent.
    87.5 If G4S did not have constructive knowledge of a medical emergency (which they did not) and had an adequate system for processing non-urgent call-outs the geographical area covered by the FME is relevant only to the viability of the section 4 sample.

88. In the light of this expert evidence, if accepted, the claimant's claims as summarised in paragraphs 72.1 and 72.2 above cannot succeed. It should be noted in addition that contrary to what the FME experts appear to have thought, a clinician was made available on call by G4S, 24 hours a day, 7 days a week. Had an emergency been foreshadowed by the police, a referral was available to a clinician and the geographical problem faced by Dr. Klotins would be irrelevant.

89. I have been invited to depart from the FME experts' evidence on the grounds that it is too timid and that there are obvious ways in which the triage system could be improved, both with regard to the making of further enquiries of the police and the improvement of the section 4 flashcard used by call-handlers, and on the basis that no system can be regarded as adequate where it relies entirely on the quality of the information provided by the referring police officers. It has been pointed out in submission that there are various points in the experts' reports where they appear to be more critical of the system than their final conclusions would appear to recognise.

90. I am not prepared to go behind the conclusions of the FME experts. Both are experienced in practice with similarly out-sourced medical services. Both have clearly considered the questions posed to them by the parties in great detail and at length and have reached measured and nuanced conclusions in the third joint statement from which it is not possible to derive any material criticism of the system as operated by G4S in the circumstances pertinent to this claim.

91. The critical question with regard to the system is whether it was adequate. Challenges to its adequacy in this case centre on whether it was properly resourced and not

stretched beyond adequate resilience and whether the triage system worked as was appropriate and intended in the particular context of the risk that a police assessment of a detainee's presentation could be wrong.

92. I do not accept that comparison with other areas such as London and Northamptonshire is materially informative. Neither do I accept the submission that the systems in these areas were clearly better. They were different. The geographical spread, population intensity and travel times and conditions are likely to be unique to each area and bare little useful comparison. Other areas may offer direct contact with clinicians at a call-centre but G4S offered 24/7 contact with a clinician in any event. I have no reason to doubt that the employment of a clinician at the call centre had been tried by G4S and had proved wasteful and unattractive to the clinicians which factors made it difficult to recruit appropriate personnel. The 24/7 telephone option was an adequate alternative.

93. The statistics derived from G4S's data in the context of the contractual requirement that 90% of call-outs met with arrival at the requesting police station within one hour are not critical either. I accept the claimant's submission that the G4S statistical data is presented in a manner most favourable to G4S and that it masks the inevitable fact that where there is a delay, that delay could be in respect of an unidentified or developing medical emergency. In addition, that data does not appear to canvass the length of the delays when they occur. The contractual margin for error reflects what is inevitable. In any system there are bound to be occasions when traffic conditions, clusters of call-outs and unforeseen staff absences compromise the target response time. A default contractual response time of an hour is, in my judgment, plainly adequate. Nobody has suggested that a wait of an hour between arrival at the hospital and admission was inadequate. A contractual margin for delays is equally adequate as it recognises nothing more than the inevitable vicissitudes affecting any responder. The risks arising as a result of any delay in arrival are adequately covered by the availability of 24/7 telephone access to a clinician.

94. As I take the FME experts to agree, the emphasis has to be on the police officers faced with a particular detainee. Where there is a call-out for a section 4 assessment, as was the case here, and where the officers make a reasonable and appropriately considered assessment that they are not facing a medical emergency, I do not consider that adequacy demands any escalation by the call-handler or that the call-handler should drill further into the police request (with or without flashcards). The section 4 assessment necessarily includes a medical assessment when the FME arrives. Fixed with actual or constructive knowledge or an actual or impending medical emergency the 24/7 availability of a clinician by telephone or resort to direct contact with the ambulance service was available to the police however long the delay proved to be in the arrival of the FME or however much circumstances conspired to reduce the number of HCPs on duty at the time.

95. The system devised by G4S clinical staff and implemented in the present case was adequate.

96. The difficulty facing the claimant's operational case against the Chief Constable comes from the facts as I have found them. The claimant was not exhibiting extensive signs of stroke at the roadside or at the police station. His was an unusual presentation. There was no justification for the police to exclude drug ingestion as a result of any profiling. The police officers conscientiously kept the claimant under review throughout his time in custody in a properly open-minded fashion but on the basis of all the information available to them about the claimant reasonably concluded he was a section 4 case and was not presenting as a medical emergency. Neither Defendant knew or ought to have known otherwise. A red flag was not on display in respect of the claimant's presentation. Had it been, it is highly likely that the police would have opted for a direct approach to the ambulance service and would have done so by 4.30am given they were aware of G4S's slower response time on this particular shift. Any geographical "stretch" affecting G4S and its FEM on this shift would have been irrelevant.

Causation - The Neurologists

97. The legal test on causation can be derived from the judgment of Lang J. in *Daniel v St. George's Healthcare NHS Trust* [2016] 4 WLR 32 beginning at paragraph 30 quoting *Smith & Emmerson, Human Rights Practice* (2015) para.2-026. The test is not controversial in its application to Articles 3 or 8.

98. The claimant must establish that as a result of any proven violations of Article 3 or 8 he has lost a real chance of the effect and consequences of his stroke being mitigated, or a real chance of a better outcome. A real chance is a substantial chance. The better outcome in this case would be the administration of thrombolytic treatment within the therapeutic window to some beneficial effect.

99. Whether there was a real chance of a better outcome for the claimant had he received thrombolytic treatment needs to be assessed at the time he was in police detention and not in accordance with common law principles of causation or loss of chance. If Article 3 is engaged in respect of either defendant any failures on their part cannot be excused on the basis that, as things turned out, the claimant would not, on the balance of probabilities, have benefited from treatment due to the size, development or positioning of the clot. Such reasoning would allow a public authority to behave unreasonably and in violation of engaged rights, and then excuse its unreasonableness on the grounds that violation made no difference to the outcome. So much is clear from *Sarjantson v Chief Constable of Humberside* [2014] QB 411 and *Griffiths v Chief Constable of Suffolk* [2018] EWHC 2538 (QB at [557]). The limited prospects of a better outcome in an individual's case with the benefit of hindsight is a matter for the assessment of damages. Nonetheless, a substantial chance of a better outcome needs to be established.

100. The claimant's case is that given that thrombolytic treatment would be offered as a matter of course had the claimant been admitted at the hospital within the therapeutic window (by 5.55am) a failure to ensure his admission by that time attributable to violations of Article 3 or 8 must have deprived him of a substantial

chance of a better outcome if only because treatment would not be offered if it did not reflect a substantial chance of a better outcome.

101. This submission could be seen to be given further force by the neurologists' acceptance of agreed statistical prospects derived from research. Statistically, there is either an 11% chance (where admission is up to 3 hours post onset of stroke) or a 6.7% chance (where admission is up to 4½ hours post onset of stroke) of a better outcome. *Assuming* it was known or ought to have been known by the police that the claimant was a stroke victim, or potentially so, even though it could not have been known at that time whether or not timely thrombolytic treatment would have any impact on his future condition, it can be known that there is this statistical likelihood that treatment could make a difference in the percentage of cases described. That statistical chance, whether 11% or 6.7% is enough for a substantial prospect of a better outcome and, it is submitted, there is no justification for placing the claimant outside the boundaries of these statistics. The better outcome would have been the mitigation of the effects of the claimant's stroke. How much better the outcome would have been, and in what way, is a matter for causation of and the measure of loss.

102. The better outcome specific to the claimant is that he is likely to have achieved a recovery at "Rankin 2" level rather than 3, with an appreciable impact on his independence and mobility.

103. There are key areas of agreement between the expert neurologists Professor Chadwick and Dr. Subramanian.

103.1 They estimate the onset of the stroke at approximately 2.25am.

103.2 They agree that it would be usual to offer thrombolytic treatment up to 4.5 hours after the onset of the stroke. That would be up to 6.55am in the present case.

103.3 It is agreed that the dominant factor determining outcome of thrombolysis is "the time to needle", that is the time at which thrombolytic treatment commences which will not be the same as the time a patient arrives at a hospital.

103.4 Statistically, the commencement of treatment between 1½ and 3 hours after onset of the stroke carries an 11% chance of an improved outcome as against no such treatment. Commencing treatment between 3 and 4½ hours after the onset of the stroke carries a 6.7% chance of an improved outcome. There was nothing in the claimant's profile or presentation to suggest he fell outside this statistical pattern which takes into account the risk of an adverse outcome such as an intracranial bleed.

103.5 They agree that other factors affect the outcome such as the size and location of the clot and the presence or absence of collateral circulation.

103.6 It is agreed that MR scanning and a CT angiogram ("CTA") on 18 May 2019 showed an occlusion of the internal carotid artery in the neck.

103.7 The timing of the CTA is not known. They agree that between the onset of the stroke and the CTA there would have been a process of organisation of the clot and this would have reduced the effectiveness of treatment.

103.8 They agree that had the CTA been undertaken during the 4½ hour therapeutic window and shown the same occlusion as was later shown this would have suggested a poorer outcome than is statistically indicated, but to a degree that is unknown.

103.9 They agree that the administration of thrombolysis would have carried with it "*some possibility*" of a better outcome, but the possibility would at all times have been small. As a matter of probability, they agree, the time of the claimant's arrival at hospital would have made no difference.

104. There are some points where the neurologists have not been able to agree. Dr. Subramanian notes the absence of any mention in the CTA of collateral circulation. No, or poor, collateral circulation would, in his opinion, make the chance of recovery "*negligible*" and would increase the risk of intracranial bleed. He considers this is particularly so in the case such as the claimant's where there was a long segment clot of greater than 0.8cm. Based on his considerable clinical experience, Dr. Subramanian's opinion was that this was a long segment, large clot and "*very proximal*" and, whilst he acknowledged the absence of any research-based statistics, his opinion was that the proximal position of the clot would make recanalization less likely with thrombolysis. Furthermore, in his experience the progression of a clot (i.e. the clot getting worse over time) was not usually seen with strokes of the type experienced by the claimant. Accordingly, he concluded that specific to the claimant the chances of a better outcome had the claimant been admitted to hospital within the therapeutic window would be much less than 6.7% and would more likely be between 1 and 2%. Had treatment been offered it would have been offered only on the basis that at the time there was nothing else available.

105. Professor Chadwick, however, considers that there was the potential for an extension of the clot as the time for thrombolytic treatment elapsed such that the earlier the treatment within the therapeutic window the greater the prospect that treatment would achieve some positive outcome. He accepted that thrombolysis would be offered within the therapeutic window because it was the only thing that was available that might work and that the closer one gets to the end of the therapeutic window the lower the prospects of achieving some more positive outcome. However, his opinion was that if the treatment worked, the benefits were real and quantifiable. In his opinion there was no reason to disapply the statistical likelihood of a better outcome in the claimant's case even though the statistics paint the general picture with a broad brush (my expression, not his).

106. In the end the question on causation is whether the claimant has established a substantial as opposed to a negligible chance of a better outcome had he been admitted to hospital within 4½ hours of the onset of his stroke. In my judgment the 6.7% chance is a substantial chance and it follows that the 11% chance would be too.

107. However, I prefer and accept the opinion of Dr. Subramanian. Assuming admission towards the end of the therapeutic window the clinical experience of Dr.

Subramanian identifies only a maximum 2% or a "negligible" chance of a better outcome. Dr. Subramanian accepted that his opinion was not open to verification from clinical testing or statistical analysis, but from his long clinical experience he was of the opinion that in all likelihood the claimant experienced a long segment clot, a large clot, at the proximal end ("very proximal" he thought) of the internal, carotid artery. He was also of the opinion based on his clinical experience that progression of the clot is not usually seen with this type of stroke (although it can happen). In the context of these clinically-based opinions, he concluded that any thrombolytic treatment offered to the claimant at the hospital would have been offered more in hope than the expectation of it having a positive effect on the outcome.

108. Professor Chadwick considered that Dr. Subramanian's opinion strayed too far from the statistics given that so much was unknown about the claimant's presentation at the hospital. I don't accept this criticism of Dr. Subramanian's evidence. On the contrary I prefer it over Professor Chadwick's because the latter's opinion is too dependent on the statistics.

Article 8

109. It is common ground that although the Article 8 case covers the same ground as the Article 3 claim, Article 8 demands a different approach. There is no "threshold" requirement for interference with private life under Article 8.1 and Article 8.1 is subject to the qualification or defence described in Article 8.2. There will be cases where the difference in approach is capable of producing a different result to that arrived at under Article 3. This case is not one of them.

Conclusion

110. It follows that the Claimant's claims must be dismissed as against each of the Defendants and there will be judgment for the Defendants.

Damages

111. Had the Claimant succeeded, to what remedy would he have been entitled? He would have been entitled to damages assessed on Convention principles. In the circumstances I need only make passing reference to the judgment of Green J. in *D v Commissioner of Police for the Metropolis* [2014] EWHC 2493 (QB) particularly paragraphs [15], [16], [17], [36], [41] and [93].

112. Both non-pecuniary and pecuniary damages would have been justified on the Claimant's claim. He did not in any way contribute to his difficulties, but he would not fall to be compensated on the basis that but for breaches of his Convention rights he would have made a full recovery or achieved an identifiably better outcome with timely treatment, neither would his non-pecuniary award be formulated on the basis that as a matter of probability his prospects of a better outcome were only 11%, 6.7% or even 2%. The non-pecuniary compensation reflects (where applicable) the violation of Convention rights not an arithmetically calculated lost chance of a better outcome had there been no violation.

113. An Amended Schedule of Damage and Future Loss puts the Claimant's claim at a sum in excess of £464,000.00. This is the sort of Schedule encountered in a domestic personal injury action. The Claimant's case is that this Schedule is merely indicative in the present case of the types of loss and expense the claimant has sustained and is likely to incur in the future by reason of the fact that he did not achieve a greater level of recovery such as would have increased his independence and earnings potential. It is also submitted that the evidence relevant to damages was not challenged in any detail (if at all) during the trial. This last submission is correct as far as it goes but is balanced by the recognition on behalf of the claimant that the Schedule is the starting point for a less scientific and more generalised approach to the calculation of even pecuniary losses.

114. I was not encouraged by any party to these proceedings to do anything other than wield a broad brush. In doing so, however, it should be noted that my findings have already included the finding that the claimant's expected level of recovery had thrombolytic treatment been administered would have only been modestly better than that which he has achieved in any event. I doubt he would have worked again and much of the losses foreshadowed in the Schedule would have been incurred regardless of any proven violation of Convention rights.

115. The appropriate figure for non-pecuniary damages would have been £10,000.00 and for pecuniary losses: £15,000.00 making £25,000.00 in total.

116. I will circulate this judgment in draft [CPR 40EPD.2 applies]. I will receive any editorial corrections directly by email and arrange for the judgment to be handed down on Friday 2 August 2019 at 10.00am. If an Order can be agreed by Counsel the attendance of the parties may be excused on that occasion. If an Order cannot be agreed I will receive written submissions on the form of Order directly by email and deal with such submissions at the handing down of the judgment. If the date of handing down is insurmountably difficult for the attendance of Counsel and submissions are necessary, I will consider setting a more convenient date at the time of handing down the judgment.

24 July 2019