Case No: B3/2009/1287

Neutral Citation Number: [2010] EWCA Civ 99

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE CENTRAL LONDON COUNTY COURT
HIS HONOUR JUDGE COLLINS CBE
7CLO2655

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/02/2010

Before :

LORD JUSTICE LAWS
LORD JUSTICE SEDLEY
and
LORD JUSTICE PATTEN

- -

Between :

DIANA SMITH	**Appellant**
- and -	
YOUTH JUSTICE BOARD FOR ENGLAND AND WALES & ANOTHER	**Respondent**

(Transcript of the Handed Down Judgment of
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Official Shorthand Writers to the Court)

Mr Scott Mattewson (instructed by Hodge Jones & Allen Llp) for the **Appellant**
Mrs Wendy Outhwaite QC (instructed by Treasury Solicitors) for the **Respondent**

Hearing dates: 1 and 4 February 2010

Judgment
As Approved by the Court

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Lord Justice Sedley :

1. This appeal concerns a claim for damages for post-traumatic stress disorder brought by a former training assistant – in substance a custody officer – at Rainsbrook secure training centre, an institution for vulnerable children serving custodial sentences. She was one of three officers whose forcible restraint of a refractory 15-year-old boy, Gareth Myatt, on 19 April 2004, brought about his death by inhalation of vomit and suffocation. The impact on the claimant was such that she was unable to continue in her employment. For this she seeks to blame the Youth Justice Board and the Ministry of Justice as successor to the Home Office, essentially because they authorised the continuing use of a dangerous system of restraint, the seated double embrace (SDE).

2. SDE is (or was) applied by three officers, one holding the trainee's head and forcing it forwards, and one holding him or her by the arm on either side. It works by inhibiting lateral chest wall movement, an effect exaggerated by increasing the degree of forward inclination. The procedure intentionally creates apnoea, with an obvious risk of asphyxia if it is used to excess.

3. The claim was tried by HH Judge Paul Collins at the Central London County Court on 28 May 2009. He dismissed it on a single ground – that although the Ministry of Justice owed the claimant a personal duty of care in this regard, and although it was in breach of it by failing to keep the use of SDE under expert review, it was less than likely that expert review would by 2004 have resulted in its abandonment. The claim thus failed for want of proof of causation.

4. The limb of the claim which asserted negligence on the Ministry of Justice part in approving SDE in the first place was abandoned in the light of the claimant's own expert evidence. This left the want of review as the sole basis of the claim. As to this it was common ground that no medical panel had reviewed the system since 1998. Changes in the training manual following a workshop in September 2002 had been directed solely to improving the effectiveness of the technique.

5. The defendants' case that the claim was barred on grounds of public policy because the claimant had been participating in an unlawful assault on Gareth was rejected by the judge and has not been renewed. The judge found that there had been a breach of Rule 38 of the Secure Training Centre Rules 1998 which forbids physical restraint except where it is necessary to prevent escape, injury, damage or incitement, and where no alternative method is available, and then only in accordance with an approved method. Alternative methods were, in the judge's view, available. But it did not follow that the restraint was a criminal assault: the judge considered that there might have been a viable claim of self-defence, and that, although the boy had been held in a forced position for seven minutes and was manifesting distress, his distress had not been sufficiently obvious to turn the restraint into a criminal assault.

6. This is not now directly challenged by the defendant. On its behalf, however, Wendy Outhwaite QC continues to rely on the facts found by the judge, and to these I shall return.

7. The judge went on to hold that the fact that the claimant was employed not by the Ministry of Justice but by a private contractor which operated Rainsbrook did not absolve the Ministry of a duty of care towards her. He did not determine what the ambit or content of that duty was – and no respondent's notice seeks to raise the issue before us – but he found on compelling grounds that if the duty ran to keeping SDE under medical review, the Ministry had been in plain breach of it. "The correspondence with officials over the years is studded with references to the need to hold a review," the judge said. "The highly sensitive nature of exercising physical force over children and the need to constantly monitor the way it was done in the light of experience made it inexcusable in my judgment for the agreed need for a review not to be treated as a priority and actioned."

8. But before considering duty and breach the judge dealt with causation. He asked whether, assuming that the duty required the defendants to conduct a medical review of SDE before 2004, such a review would more probably than not have led to the banning of SDE. It was banned following Gareth's death. But Judge Collins found that it was impossible to say what would have happened had the 1998 medical panel, or its equivalent, been reconvened towards 2004: they might or might not have advised banning it.

9. It is this conclusion which the claimant attacks on this appeal, for which Waller LJ gave permission on sight of the papers; and with reason. The figures for Rainsbrook alone showed that in the twelve months before Gareth's death, SDE had been used 369 times. In almost one case in three some form of harm had been caused by it, and in almost a third of these – about 10% of the total – the harm had been life-threatening. We do not know how far these figures were replicated elsewhere.

10. Although the initial issue on this appeal is whether the judge was right to find causation not established, for reasons to which I am about to come the focus of the argument on causation has shifted. I will not therefore set out either the judge's detailed findings about the likelihood that an expert review would have resulted in withdrawal of SDE by 2004, nor the cogent grounds of appeal against the finding.

11. Mrs Outhwaite's skeleton argument advanced different grounds for finding causation not established. They raise the fundamental question whether the appellant's participation in a needless and excessive restraint means that responsibility for the trainee's eventual death rests with her and her colleagues rather than with the state. But there was no respondent's notice, as there should have been, spelling this out. It seemed to the court that the appeal could not be justly dealt with unless this too was on its agenda, but that it raised questions of law which the appellant's side were entitled to consider without undue pressure. We therefore gave Mrs Outhwaite permission to put in a respondent's notice but adjourned the hearing for three days to give the claimant's lawyers the time they needed to deal with it.

12. The Ministry's alternative grounds for upholding the judgment are these:

> "1. Mrs Smith asserts that she was obliged to implement a particular system of restraint which was dangerous and caused, in turn, Gareth Myatt's death and Mrs Smith's psychiatric injury. However, the learned judge found that Mrs Smith did not in fact follow the prescribed system of restraint: Mrs Smith

> neither complied with the requirements of the Secure Training Centre Rules 1998 nor the PCC Manual – which is the method of restraint approved by the Secretary of State. The Defendant is not responsible for the harm sustained by Mrs Smith when she does not follow the prescribed system of restraint.
>
> 2. As Mrs Smith did not follow the prescribed system of restraint, it did not cause her loss.
>
> 3. Alternatively, Mrs Smith‘s failure to follow the prescribed system of restraint, which was therefore an unlawful restraint, constituted a supervening event which broke the chain of causation."

13. Mr Matthewson has objected that these grounds seek to impugn the appellant's conduct not only in the course of the restraint but in the events leading up to it. Had it been apparent, he says, that it was to be part of the case he had to meet that the entire exercise had been embarked on unlawfully, he would have wanted to consider calling Mr Beadnall as a witness to explain why he had initiated it. Leaving aside the distance between considering such a step and deciding that it is prudent to take it, I do not accept that the issue was not before the judge, albeit he did not deal frontally with it. It formed part of the pleaded defence and featured in the Ministry's written closing submissions. The time to object, if objection was to be taken, was then. I do not mean this as a criticism: it is often better for counsel to let an issue be addressed than to take a pleading point which may make it look as if one is worried about it. But I accept Mrs Outhwaite's submission that the issue was open before the judge, as it now is before us.

14. Gareth had started a 12-month sentence for assault and theft three days before the tragedy occurred. On the day of his death he had made and eaten a toasted cheese sandwich and had then refused to clean the toaster. To defuse the situation another trainee did it for him, but an officer named David Beadnall required him to go to his room. This constituted removal from association, which is governed by rule 36 of the Secure Training Centre Rules 1998. The judge found that this step, a measure of last resort, had been unnecessarily and therefore improperly adopted. It was, however, the occasion rather than the cause of what followed.

15. The claimant and Mr Beadnall followed Gareth into his room and began clearing it of items which were not his. Beadnall then started removing Gareth's own belongings, among them a piece of paper containing his mother's telephone number and his other links with the outside world. This act the judge described as disproportionate and unjustified in itself, and as a clumsy and ill-judged way of teaching Gareth a lesson for his earlier behaviour. Gareth reacted to it by raising, and possibly thrusting, his fist in Beadnall's direction.

16. The use of forcible restraint is closely regulated by rule 38. The material reason for it here, if any, had to be that restraint was necessary to prevent Gareth injuring an officer. Even then force was permitted by the rule only where no alternative method was available. And if force was used, the rule limited it to the use of an approved method by a trained officer. Gareth stood 4'10" and weighed 6½stone. Beadnall was 6' tall and weighed some 14 stone. On the evidence there was no sensible possibility

that Gareth was going to injure him. As the judge found, it was unnecessary to do anything except shut him in his room.

17. Instead, Beadnall 'enveloped' Gareth and pushed him on to the bed. Gareth – as in law he was by now entitled to do – struggled and kicked out. A third officer, David Bailey, was summoned, and the three officers then applied SDE to Gareth. Had the issue been open before us, it would have taken a great deal to persuade me that this was not a criminal assault. What matters now, however, is what ensued.

18. What ensued is in my judgment fairly and accurately described in the defence:

> "(1) Gareth Myatt was held by the Claimant and others in a position where his upper body was bent over at an acute angle so that his head and chest was too close to his thighs and knees which resulted in his respiratory system being prevented from functioning properly. This is not a hold which complies with PCC;
>
> (2) Gareth Myatt was restrained for an excessive period of time, notwithstanding that he was a small in stature and was easily overpowered by three adults and, after a time, did not resist. This does not conform to PCC and is an excessive use of force;
>
> (3) Gareth Myatt continued to be restrained notwithstanding his obvious physical distress which was communicated to the Claimant by Gareth Myatt as follows:
>
> > (i) he said that he could not breathe;
> >
> > (ii) he said that he was '*going to shit himself*'
> >
> > (iii) he defecated;
> >
> > (iv) he became motionless, irresponsive, unable to support his own body weight and was supported with his eyes shut, but the Claimant continued to restrain him.
>
> (4) Gareth Myatt was not released as required by the hold release option in PCC given that he was suffering from physical distress;
>
> (5) Gareth Myatt was not adequately monitored as required by PCC.
>
> In the premises the Claimant's restraint of Gareth Myatt was unlawful in that
>
> > (i) it did not conform with PCC; and
> >
> > (ii) excessive force was used. "

To this it should be added that the boy had become very red in the face – a further recognised sign of distress.

19. The process took some seven minutes. By the time the boy was released he was unconscious and inert, though he still had a pulse. The wrong first aid was administered; then the ambulance crew had difficulty getting into the institution; but the pathologist's evidence at the inquest was that Gareth was all but dead by the time the officers' hold on him was relinquished.

20. All three officers had been given training in what is known as PCC (Physical Control in Care), which includes the SDE technique. Both the training and the manual require, first, the maintenance of a dialogue with the trainee, explaining what is going on and attempting calm him and secure his cooperation; and secondly, continuous monitoring both of the position in which the trainee is being held and of any signs of distress which may indicate that the incident has become a medical emergency. Specifically the manual says:

> "Where continued application of physical holds by staff on a trainee becomes unsafe for the trainee or staff the hold(s) must be released. Safety of all involved with the restraint is the priority."

This guidance is echoed at several places in the part of the manual dealing with SDE.

21. These principles were disregarded by the claimant and her colleagues. Gareth was held so that he could not maintain his breathing; the physical distress caused him first to soil himself and then to regurgitate his food; the posture in which he was held made him inhale it instead of expelling it; and it was continued for so long that life was extinguished.

22. Judge Collins, as I have said, held that this was not conduct sufficiently reprehensible to bar the claimant's case on grounds of public policy. He also accepted (§14) that Beadnall had acted in good faith and (§17) that "had the claimant and the other officers appreciated earlier that Gareth's symptoms were genuine and significant, the hold would have been relaxed". But this leaves open the question whether they should have appreciated it. If not, the claimant's case that the technique itself was potentially lethal becomes all but unanswerable. If, however, the technique was capable of being used safely provided staff were careful and observant in using it, the picture changes.

23. Among the signs of distress which Gareth manifested during the critical seven minutes were these: he said that he could not breathe; he said that he was losing control of his bowels; he did so; he vomited; finally he slumped motionless. Each of these signs of increasing distress was readily perceptible to the officers; there was no reason to think any of them was not genuine; although the claimant had in fact been trained in first aid, no medical expertise was required to recognise either their reality or their seriousness; yet the child continued to be held in the SDE position until life was all but extinct. The claimant herself candidly said in evidence that "common sense went out the window".

24. The immediate cause of Gareth's death was thus, on the evidence, the use of a permitted technique to excess. The secondary cause was the irregular provocation by

two of the officers involved (one of them the claimant) of the situation in which the technique had been deployed. It is only if such excessive use was inherent in the permitted system that a tertiary responsibility may rest on the state; and even then the respective responsibilities would have to be evaluated and weighed.

25. The claimant's case, which her counsel submits would have succeeded below but for a faulty finding on causation, is precisely that SDE was a dangerous technique which ought to have been abandoned before April 2004. There is no question that if this was going to happen it would have been the responsibility of the state, now in the form of the Ministry of Justice, to ensure that it happened.

26. Although there were serious questions about the adequacy of staff training, the claimant's case was not that she was inadequately trained: it was that she had competently administered a form of restraint which the Home Office knew or should have known was inherently dangerous.

27. I have set out earlier in this judgment some of the judge's findings on causation. To them it is necessary to add what he found in relation to breach of duty. Having observed that his finding on causation made the topic academic, Judge Collins said:

> "21. …. But it is right for me to make some observations about these issues since they are central to the case. If the defendants or either of them were under a duty to hold a review with a medical element, it is plain that they were in breach of it. The correspondence between officials over the years is studded with references to the need to hold a review. The highly sensitive nature of exercising physical force over children and the need to constantly monitor the way in which it was done in the light of experience, made it inexcusable in my judgment for the agreed need for a review no to be treated as priority and actioned. I have heard no evidence explaining what went wrong. Mr Mark Perfect was chief executive of the Youth Justice Board at the relevant time and told me that PCC was the responsibility of the Home Office and that he believed a review should have taken place. I accept the evidence of Dr Bailey that in 1998 the reviewing panel expected as a result of the discussions took place there would be regular reviews. Mrs Outhwaite argued that the frequent references to review referred to a review thought to be necessary because of the deficiencies of PCC as a code for the restraining of children. But that was to take the correspondence out of context, in my judgment. The sensitivity of the procedures and the involvement of a medical panel in 1995 and 1998 underlay the whole process. This was emphasised by the evidence of Dr Bailey and of Mr Stevens, whom was employed by the Social Services Inspectorate, then seconded to the Home Office for the design of secure training centres and subsequently employed to manage Rainsbrook and other centres. He told me that 'we knew injuries had been caused inadvertently and we needed to know that unintended consequences had not occurred.' He was, I think, taking about the situation in 1995 but he

> emphasised the sensitivity of the issue. It seems to me that this sensitivity will never disappear as long as force is used on children in custody. The failure to hold regular reviews of PCC with an independent medical panel is both inexcusable and unexplained."

28. It is impossible in the light of these findings, despite their contingent character, to absolve the Home Office (which had responsibility at the time) of blame for its passive and complacent attitude to the need to monitor, and if necessary to modify or abandon, a technique which was known to have resulted in injury to children in custody. Whether the risk of injury was inherent in the technique itself or resulted from over-use or abuse of it, the need for competent monitoring and response was the same.

29. The potentially decisive question for us is therefore this: if an appropriate measure of vigilance on the part of the Home Office not only should but probably would have resulted in withdrawal of SDE by the material date, is the harm suffered by the claimant in consequence of her use of the technique compensable in damages? The answer falls into two parts. If all that had happened was what the claimant asserted had happened, namely that an appropriately measured use of SDE had had a fatal outcome, then, subject to issues of the scope and nature of the duty of care which are not before us, and to the question of causation, she would be entitled to succeed. But if, as is inescapable, what happened was that she and her colleagues used the technique both unnecessarily and excessively and its excessive use brought about the death which has caused her harm, a different kind of judgment is called for. It becomes necessary to evaluate what is sometimes called the relative potency of the two causes, but is better regarded today as whether in fairness the claimant's own role in bringing about the harm of which she complains eclipses or displaces any prior fault on the part of those who placed her in that role.

30. For the purposes of making this evaluation it is necessary to assume, as I readily do, that the judge was mistaken in declining to find that a timeous professional review of SDE would have resulted in its abandonment by 2004. It seems to me to sit very ill indeed in the mouth of a responsible department of state to assert that the expert review which it neglected to institute would more probably than not have left this hazardous method of restraint in place. But to characterise it as hazardous is not absolve those who used it of responsibility for using it properly, any more than selling a weapon absolves anyone who handles it of the need to do so with great care.

31. What then is the test which we are required to apply to the facts I have outlined? It is today well established that causation is in essence a question of fairness. Lord Justice Laws in his judgment in *Rahman v Arearose Ltd* [2001] QB 351, §33, (cited with approval by Lord Bingham in *Fairchild v Glenhaven Funeral Services Ltd* [2002] UKHL 22, §12) explained the issue as one of responsibility. In *Spencer v Wincanton Holdings Ltd* [2009] EWCA Civ 1404, §15, I said that a succession of consequences which in fact and in logic is infinite will be halted by the law when it becomes unfair to let it continue. Lord Bingham had lucidly explained why in *Corr v IBC Vehicles Ltd* [2008] UKHL 13, §69-70.

32. Factual causality, it follows, is the first but not the only step. Applying it here, there is no doubt that but for the sanctioning by the Home Office of SDE as a means of

restraining young offenders, none of this would have happened. But the second step is to ask to what point the state ought in fairness to be regarded as responsible, and so held liable for the sequence of consequences.

33. Between the Home Office's authorisation of SDE and Gareth's death two significant things intervened: the use of the technique on him in breach of rule, and the continuance of it in spite of his manifestations of distress. Are these at most forms of contributory fault (a possibility which the judge considered but rejected), or are they to be fairly regarded as supervening causes of the trauma which the appellant herself eventually suffered? In my judgment the latter is the case.

34. First, the unnecessary use of SDE on Gareth, in breach of rule, made it an assault which in law he was entitled to resist and in which the appellant, who knew how it had come about, became a participant.

35. Secondly and separately, the signs that it was necessary to release the three officers' hold on him were in my judgment clear and were ignored. I take full account in this regard of Mr Matthewson's submission that there was no good reason to appreciate this at the time: it was a common fallacy that if a trainee could say "I can't breathe" he must in fact be able to breathe; it was perfectly possible that a trainee would not only threaten to soil himself but would actually do so in order to get released; by the time some vomit escaped, his lungs would already have been filled with it; and slumping inert could well have been another subterfuge. If the officers had been dealing with a large and violent youth whose release, if he was not in truth in distress, might have enabled him to attack them, one could at least have understood their reluctance to release him. But this was an undersized, underweight 15-year-old who had done no more than show his fist to an officer twice his size – an officer who, moreover, had provoked him into doing it by a pointless and insensitive act. When one recalls the clear advice in the manual to release the hold if it became unsafe for the trainee, the repeated ignoring or misreading of his signs of distress becomes inexcusable. As the appellant herself said in evidence, for those seven minutes common sense went out of the window. There were perfectly safe ways of controlling Gareth, assuming that control was still needed, which did not involve SDE.

36. None of this necessarily represents a finding of legal culpability against the appellant or her colleagues: that is not the purpose of the present inquiry. Its purpose is to decide whether it can be fairly said that responsibility for Gareth's death (and hence for its effect on the appellant) rests anywhere but on those who brought it about, one of whom was the claimant. Although, for reasons I have given, no credit goes to the Home Office for having kept in being the system of restraint which enabled the tragedy to occur, its actual occurrence was the responsibility of the appellant herself, albeit with others. It would be rightly regarded as unjust if she were to recover damages for its effect on her.

37. I would so hold, not on grounds of public policy, which the judge rejected and have not been resurrected, but on grounds of causation which, although broached below, have been fully argued only in this court. The judge's own reason for rejecting causation, which I have given my reasons for doubting, becomes correspondingly immaterial.

38. I would dismiss the appeal.

Lord Justice Patten:

39. I agree.

Lord Justice Laws:

40. I also agree.