IN THE NEWCASTLE COUNTY COURT No. E23YJ998

Newcastle Civil and Family Courts and Tribunals Centre
Barras Bridge
Newcastle-upon-Tyne
NE1 8QF

Wednesday, 19 May 2021

Before:

HIS HONOUR JUDGE FREEDMAN

B E T W E E N :

LEANNE WALSH
(as Administratrix of the Estate of Gareth Walsh (Deceased))
(& 7 others) Claimants

- and

NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST Defendant

MR W. YOUNG (instructed by Irwin Mitchell Solicitors) appeared on behalf of the Claimants.

MS N. WHITTAKER (instructed by DAC Beachcroft LLP) appeared on behalf of the Defendant.

J U D G M E N T

JUDGE FREEDMAN:

Introduction

1 This is a tragic case. On 4 February 2017, Mr Gareth Walsh ("the deceased") took his own life by running onto the A189 Spine Road in Northumberland, into the path of oncoming traffic. He was then aged thirty-six. Immediately prior to the incident, he had absconded from the Northumbria Specialist Emergency Care Hospital ("the hospital"), where he was being treated.

2 A claim has been brought on behalf of the estate of the deceased, by his widow, and on behalf of his dependent children. The claim is framed in Common Law negligence. In general terms, it is alleged that the hospital, through its security guards, was negligent in permitting the deceased to leave the hospital, whereby he was able to commit suicide.

3 The hearing before me was concerned solely with the issues of liability and causation. Originally, it was intended that the court should receive expert evidence from Consultants in Accident and Emergency medicine (and, indeed, from Nursing Experts, albeit only in written form), but at the Pre-Trial Review, it was agreed on all sides that the issues which fell for determination, at least in large part, fell outside the ambit of "expert opinion". However, and in so far as the experts were in a position to shed any light on the issues, their respective reports and joint statements were available for reference purposes.

4 As to lay evidence, again, in the event, it was not necessary for the court to receive any *live* evidence. A witness statement from the Physician's Assistant (Karen Gibson) who had some dealings with the deceased on the morning in question was available to the court, but

her evidence was not disputed and, therefore, cross-examination was not required. The two witnesses who might have been able to assist the court with oral evidence were the two security guards. However, Mr James Simmonds has died subsequent to this incident and Mr Kyle Mailer is on long-term sick leave and was not in a position to attend at court. Nevertheless, there was available the witness statement provided by Mr Simmonds for the purposes of the coroner's inquest and a witness summary was provided on behalf of Mr Mailer.

5 In the event, therefore, the court did not hear any oral evidence. The hearing proceeded exclusively on the basis of oral submissions. In advance of the hearing, both counsel provided very helpful written skeleton arguments.

Background

6 It appears that, until January 2017, the deceased had no history of a psychiatric illness. However, on 23 January 2017, an allegation was made that he had struck one of his children. As a result, he was required to leave the family home. This appears to have resulted in him taking an overdose of paracetamol on 30 January 2017, but, on that occasion, no medical attention was sought.

7 On 4 February 2017, having taken another overdose of paracetamol, the deceased was taken by ambulance to the hospital. This was shortly before 6.30 a.m. Unfortunately, because of the number of patients requiring treatment, the deceased was not seen by a doctor until 12.52. The plan was for N-acetylcysteine to be administered, and this was commenced at 14.18. Additionally, bloods and venous gases were checked. The deceased was taken to the

Green Hub interview room ("the room") pending admission to Ward 3 and a psychiatric review.

8 At approximately 15.15, the Physician's Assistant, Karen Gibson, found that the deceased was not present in the room. She located him by the smoking shelter immediately outside of the hospital. He told her that because the hospital was not doing anything to help him, he was going to kill himself. Ms Gibson did her best to re-assure him that he would be given a bed as soon as one became available. She asked him to come back into the hospital and he agreed to do so. But, as they approached the main entrance, he ran away towards the disabled parking area. From there, there was easy access onto the A189, either through or over a low wooden fence. Ms Gibson requested a colleague to summon security. In a very short time, Messrs Mailer and Simmonds joined Ms Gibson and they gave chase to the deceased. The security guards were able to catch up with the deceased who, at that time, was standing on the bank next to the A189. A conversation took place before the deceased then agreed to walk back to the hospital, in the company of the security guards.

9 On arrival at the main entrance to the hospital, the deceased asked for a cigarette from a female who was standing by the door. Whilst smoking a cigarette, the deceased said words to the effect: "*I was meant there, like. I was going to jump*". Mr Simmonds subsequently explained that he understood the deceased to be saying that he intended to run into the road.

10 After finishing his cigarette, the deceased returned to the A&E Department, accompanied by the security guards. En route, he stopped to use the toilet. The security guards remained outside the toilet whilst he did so. The deceased then returned to the room. Within a few seconds, he left the room and walked to the water cooler, which was close by, and obtained a cup of water. The security guards followed him to the water cooler, and directed him back to the interview room. The deceased duly returned to the interview room.

11 There are some photographs of the interview room. It shows that there are two doors at either end of the room. Mr Simmonds positioned himself outside one door and Mr Mailer stood outside the other door. Within a very short time (probably less than a minute) the deceased opened the door where Mr Simmonds was stationed and asked him for some more water. Mr Simmonds took the plastic cup which the deceased was holding and walked off towards the water cooler. Photograph KM5 would tend to suggest that the water cooler was no more than approximately twelve paces from the door where Mr Simmonds was positioned.

12 After walking a few paces (according to his statement, three steps), Mr Simmonds turned round and saw that the door to the room was closing and the deceased was running down the corridor towards the exit of the A&E Department. He shouted to his colleague, Mr Mailer, that the deceased was running off. He then gave chase to the deceased through the reception area, across the disabled car park and wasteland beyond. Unfortunately, Mr Simmonds could not catch up with the deceased, who made his way up the embankment and onto the grass verge of the southbound lane of the Spine Road. By the time Mr Simmonds and Mr Mailer reached the grass verge on the east side of the Spine Road, it was too late: the deceased ran into the southbound carriageway, into the path of approaching vehicles. Although one or two vehicles were able to take evasive action, the deceased, while standing in the centre of the two southbound lanes, stepped directly into the path of an oncoming VW Golf. The deceased was pronounced dead at the scene of the accident.

Issues

13 Following the Pre-Trial Review, counsel agreed upon a list of issues for determination at the trial, as follows:

(1) After the deceased voluntarily returned to A&E at 15.39 hrs, what did the security guards (Mr Simmonds and Mr Mailer) do?

(2) Did the security guards take reasonable care of the deceased in the circumstances. In particular:

was it a breach of duty of care on the part of Mr Simmonds to start to fetch the deceased a glass of water when asked for one?

(3) But for any breaches of duty, if established, would the deceased still have left A&E (with the same consequences) at or around the same time in any event?

14 The first issue, as identified above, is a factual inquiry which is uncontroversial. Indeed, the sequence of events which I have set out at paragraphs 8-12 above would seem to provide the answer to question 1. No further analysis is required.

15 Question 2 is the fundamental issue in the case. But it does seem to me that, before consideration can be given to whether there was a breach of duty of care on the part of the security agents, it is necessary to define the nature and extent of the duty which was owed to the deceased in these particular circumstances. This may be considered to be, to a large extent, self-evident and there would not seem to be much dispute between the parties, but it should be clearly stated. I would frame it in this way:

The duty of care owed by the security guards to the deceased was to take reasonable care for his safety; and in the particular prevailing circumstances, that included a duty to take reasonable measures to prevent him from absconding from the hospital.

16 Question 3 and the issue of causation only arises if a breach of duty is made out.

Breach of Duty (Claimants' Case)

17 Understandably, Mr Young predicates his submissions on the underlying premise that it was foreseeable that the deceased might attempt to leave the hospital and to commit suicide. In this respect, he relies upon the following matters:

(i) The reason why the deceased was in hospital was because he had taken an overdose of paracetamol and, indeed, he had done so a few days earlier.
(ii) Of some importance, the deceased had already made one attempt to leave the hospital, apparently with the intention of running into the road, into oncoming traffic.
(iii) The remarks made by the deceased to the security guards made it clear that it had been his intention to commit suicide.

18 Mr Young further relies upon the joint statement from the A&E experts. They agree that the deceased ought to have been considered as being at a high risk of re-absconding; and that it was foreseeable that he would make a further attempt to harm himself.

19 It is also the case that the security guards themselves were alert to the risk of the deceased absconding and with grave consequences, were he to do so. Mr Young, in particular, refers to the fact that although the deceased appeared to cooperate as he was being escorted back

to hospital after his first absconsion, when he looked over the top of the railings, Mr Mailer apparently moved closer to him (*just in case*). Thus, says Mr Young, they had actual knowledge that he was at a high risk of attempting suicide.

20 In these circumstances, given the real risk that the deceased would seek to leave hospital and the potentially grave consequences in the event that he did so, Mr Young submits that there was a heavy duty on the security guards to prevent the risk materialising. In practical terms, what Mr Young submits is that the security guards could and should have kept the deceased under observations at all times. In support of this proposition, he says that that was a responsibility which was in fact assumed by the security guards in that they positioned themselves at each of the two doors. He submits that the only reason for doing so was so that the deceased could be prevented from leaving the room and then the hospital. He asks, rhetorically, what was the point of having two guards stationed at either door if not to prevent the deceased from leaving the room and, in that way, to keep him safe.

21 Mr Young further submits that it was entirely foreseeable that if one or other of the doors was left unattended, even for the briefest period of time, the deceased might attempt to leave the hospital. Further, he submits that it was an unnecessary risk for the guard to take. There were many other obvious practical solutions which could have been adopted, so as to enable the deceased to be given a second glass of water, without him being left partially unattended in the room. For example, Mr Young suggests that another member of staff could have been asked to fetch the water. In the alternative, Mr Simmonds could have asked Mr Mailer to come into the room and stay with the deceased whilst he, Mr Simmonds, went to the water cooler. A yet further possibility was to invite the deceased to go with Mr Simmonds to the water cooler and, in that way, a close eye would have been kept on him.

22 Distilling the various propositions advanced by Mr Young, it comes to this: leaving one of the doors of the interview room unattended, albeit only for a few seconds, constituted a breach of duty of care on the part of Mr Simmonds in that he afforded the deceased the opportunity to leave the hospital in circumstances where it was foreseeable that he would do so.

23 Obviously, the claimants' case can only be made good if it is established that there were steps which could and would have been taken to prevent the deceased from leaving hospital, in the event that he tried to do so. Notwithstanding the absence of any statutory powers to detain him, I am satisfied that if either Mr Mailer or Mr Simmonds were aware that the deceased was attempting to abscond, they would have physically restrained him. Whilst they may not have had a statutory power to do so, as a matter of common sense, bearing in mind that they knew he was a suicide risk, they would have done whatever was necessary to stop him from leaving the hospital.

Breach of Duty (Defendant's Case)

24 Part of Ms Whittaker's skeleton argument addresses the *doctrine of necessity*. As I made clear in the course of oral argument, it seems to me that the issues which arise in this case do not involve consideration of the *doctrine of necessity*. Accordingly, I do not consider it necessary to say anything further about the *doctrine of necessity* in this judgment.

25 Similarly, I do not consider it instructive to look at the provisions of the Mental Health Act 1983. Manifestly, the deceased was not being detained under the Mental Health Act. To the contrary, a medical review was awaited before decisions were made about his management. There was, therefore, no statutory power to detain him in hospital. He was at liberty to leave the hospital if that is what he chose to do.

26 However, whilst he was, in theory, free to leave the hospital, as I have already observed, in reality, if the security guards had been alert to the fact that he was attempting to abscond, they would have done what was necessary to prevent him from so doing.

27 What does go to the heart of the defendant's case is Ms Whittaker's submission that it was not reasonably foreseeable that, when Mr Simmonds went to the water cooler, the deceased would attempt to abscond from the hospital. The point is made that, after his first attempt to abscond, he willingly and voluntarily returned to the hospital. It appears that little persuasion was required, and certainly no force. On his return to the interview room, he did not present as being either agitated or aggressive. In short, Ms Whittaker submits that although, in general terms, he could be termed to be a *suicide risk*, at the time when Mr Simmonds went to the water cooler, there was nothing in his presentation or behaviour to suggest that he was going to make a further attempt to abscond.

28 Ms Whittaker also emphasises the fact that there was a need to balance, on the one hand, the requirement to keep the deceased safe but, on the other, not to be overbearing or unduly protective such as to alienate him. It was important to preserve his cooperation whilst, at the same time, doing what was necessary to keep him reasonably safe. Ms Whittaker submits that these were competing considerations which had to be balanced in the minds of the security guards when deciding what should or should not be done when looking after the deceased.

29 Ms Whittaker puts the matter in this way at para.13 of her skeleton:

> "*Given that the competing considerations that would have reasonably been taken into account by Mr Simmonds when agreeing to refill a cup of water,*

the niceties of a careful consideration of the exact way in which the deceased might seek to outsmart his watchful eye would not have been reasonably available to Mr Simmonds in a split moment when he had to make a decision of whether to refuse a reasonable request for water from the deceased, thereby risking to alienate him, increasing his sense of frustration and, ultimately, escalating his risks."

30 Ms Whittaker makes the further point that it was not foreseeable that the deceased would use the request for a second cup of water as a *ruse* to enable him to make good his escape. But as Mr Young points out, for the purposes of foreseeability, it is not necessary for the precise method deployed by the deceased to leave the hospital to be foreseen: it matters not whether it was opportunistic or planned a few moments in advance. I am inclined to agree with Mr Young, but the central point remains as to whether or not it was reasonably foreseeable that, at that particular time, when Mr Simmonds was away from the door for a few moments, the deceased would attempt to leave the hospital.

My Analysis

31 I have already made certain observations, inevitably, in the course of reviewing the parties' respective submissions. But it would perhaps be useful for me to set out, in tabular form, my assessment of the key matters before reaching a conclusion as to whether there was a breach of duty on the part of Mr Simmonds, as follows:

(i) For the reasons identified by Mr Young, it is plain that, in general terms, there was a risk of the deceased absconding from the hospital.

(ii) Similarly, in general terms, there was a risk that the deceased would, in some way or another, attempt to commit suicide.

(iii) The role of the security guards was to keep watch over the deceased, with a view to keeping him safe within the hospital environment.

(iv) The purpose of each guard standing outside the two doors to the interview room (as was recognised by the security guards themselves) was to ensure, as far as was reasonably practicable, that he did not leave the building.

(v) The function of the security guards was not, however, to guard or detain him in the conventional sense: it was to take reasonable steps to prevent him from leaving the hospital.

(vi) In the short period immediately prior to the deceased running out of the hospital, there was nothing in his demeanour to suggest that he was contemplating an escape. To the contrary, the evidence suggests that he was calm and cooperative.

(vii) It was both reasonable and appropriate for Mr Simmonds to respond to his request for a refill of water.

(viii) Mr Simmonds had to make a *spur of the moment* decision as to whether to absent himself from the door for a few moments in order to go to the water cooler.

32 With the above in mind, the ultimate question which has to be answered is whether Mr Simmonds was in breach of his duty of care to the deceased in leaving the door unattended for a few moments whilst he went to the water cooler. That question, in turn, requires consideration of whether it can properly be found that Mr Simmonds should have reasonably foreseen that his absence from the door would have been used by the deceased as an opportunity to re-abscond. Of course, there was a risk that, at any given moment when

the deceased was not being observed, he might seize upon the opportunity to make good his escape. But that is not the same as saying that there was a foreseeable risk that he would abscond if any opportunity, however brief, presented itself.

33 I remind myself that in a case such as this, context is everything. I also remind myself that there is a real risk of importing a degree of artificiality, if a court focuses on a brief moment of time rather than looking at the whole picture. In my judgment, it is too easy to conclude, that with the benefit of hindsight, there were practicable measures which could have been taken to have avoided the deceased being left (partially) unattended for a few moments. I am inclined to agree with Ms Whittaker that what is contended for on behalf of the claimant is a counsel of perfection, informed by the benefit of hindsight. To adopt the words of Green J in *Mulholland v Medway NHS Foundation Trust* [2015] EWHC 268 (QB) at [101], the standard of care "*must be calibrated in a manner reflecting reality*". (That case was, of course, on very different facts, but the principle is of universal application).

34 It can properly be inferred from the actions of Mr Simmonds that he did not consider that there was any or any appreciable risk that the deceased would seek to abscond in the few moments it would take to go to the water cooler and return to the interview room. It is, as I say, easy, retrospectively, to challenge that decision, given how events unfolded. But the critical question is whether, at the particular moment when Mr Simmonds decided to respond to the deceased's request for a cup of water, he was acting negligently. To come to such a conclusion would, in my view, be to impose an intolerably high burden on a security guard carrying out a difficult task in a hospital setting. Even if it were to be said that it was an error of judgment on the part of Mr Simmonds, that goes nowhere near to amounting to a breach of duty of care.

Causation

35 For the sake of completion, I need to touch upon the issue of causation, albeit that, in the circumstances, the debate is somewhat sterile. I am asked by the defendant to find that even if there was a breach of duty on the part of the security staff, the reality is that the deceased would have found an opportunity to abscond within a short time, in any event. This is on the basis that it is now clear that the deceased was very determined to commit suicide and he would have done so if not physically detained. Mr Young submits that it is entirely speculative to conclude that, on balance, the deceased would have found another opportunity to commit suicide within a short time of the water cooler incident.

36 There is, inevitably, a degree of speculation in addressing the issue of causation. On balance, however, given the deceased's actions at the time when Mr Simmonds went to the water cooler, there is a legitimate basis for concluding that he was intent upon leaving the hospital, at the first opportunity and taking his own life. Accordingly, and since, as it seems to me, it was highly likely that other opportunities would have arisen for him to leave the hospital during the course of the afternoon of 4 February 2017, before such time as he received medical treatment, question 3 falls to be answered in the affirmative.

Conclusion

37 In conclusion, therefore, whilst, of course, having every sympathy for the claimant and her family, I am constrained to find that the deceased's suicide cannot be attributed to any breach of duty on the part of the NHS Trust. Moreover, and even if I have erred in relation to my finding as to the absence of negligence, I am satisfied that causation is not established in this case, in the sense that it seems to me probable that the deceased would have found a way to leave the hospital and end his life within a short time, even if he had not been left unattended by the door when Mr Simmonds went to the water cooler.

38 Finally, I am grateful to counsel for their assistance in this difficult and anxious case. I invite them to draw up an order to reflect my judgment in this case.