Neutral Citation Number: [2022] EWHC 3003 (KB)

Case No: QB-2021-001271

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 25/11/2022

Before :

MRS JUSTICE HILL DBE

- -

Between :

MS ANGELA CARR — **Claimant**

- and –

G4S CARE AND JUSTICE SERVICES (UK) LIMITED — **Defendant**

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- -

Sam Jacobs (instructed by Bhatt Murphy) for the **Claimant**
John-Paul Waite (instructed by DWF Law LLP) for the **Defendant**

Hearing date: 7 November 2022

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Approved Judgment

This judgment was handed down remotely at 10.30am on 25 November 2022 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Mrs Justice Hill DBE:

Introduction

1. By this claim, issued on 11 October 2019, the Claimant brings proceedings against the Defendant arising out of the death of her son, Andrew, on 29 March 2018. He died while a serving prisoner at HMP Birmingham, from the use of a synthetic cannabinoid. This is part of a group of substances known as Psychoactive Substances ("PSs") or New Psychoactive Substances ("NPSs").

2. At the time of Mr Carr's death, the Defendant was contracted to run HMP Birmingham, having been awarded a contract to do so for 15 years in 2011.

3. The Claimant's claim is advanced as a breach of two of the duties arising under the right to life in Article 2 of Schedule 1 to the Human Rights Act 1998 ("the HRA"), namely the 'general' duty and the 'operational' duty.

4. By an application notice dated 27 March 2020 the Defendant seeks an order striking out the claim under CPR 3.4(2)(a) and/or granting summary judgment for the Defendant under CPR 24.2(a)(i) and (b).

5. When the application was issued it was supported by one witness statement, from the Defendant's solicitor, Suzanne Farley, dated 23 March 2020. This focussed solely on the operational duty element of the Claimant's claim. The Claimant responded with a witness statement from her solicitor, Simon Creighton, dated 16 April 2020.

6. The application was due to be heard by District Judge Jackson in the County Court at Mayors and City of London Court on 9 December 2020. Shortly before the hearing the Defendant filed a skeleton argument. This raised, for the first time, the argument that an allegation of breach of the general duty could not be brought against a private contractor, such as the Defendant, meaning that the Claimant had no real prospect of establishing a breach of the general duty.

7. The District Judge adjourned the application and transferred the case to the High Court. Provision was made for further evidence to be filed and served. Both parties served further statements from their solicitors: for the Defendant, a statement from Andrew Holland dated 2 January 2021 and for the Claimant, a statement from Carolynn Gallwey dated 7 October 2022.

The facts and the evidence

8. The following summary of the factual context is taken from the Particulars of Claim and the evidence provided for the purposes of the application. The reports and other documents referred to below were exhibited to the various solicitors' statements.

Events leading up to Mr Carr's death

9. On 6 July 2017 Mr Carr was remanded in custody to HMP Birmingham. On 3 August 2017 he was sentenced to three years and four months imprisonment for offences of burglary and theft.

10. On 18 August 2017 he was transferred to HMP Stoke Heath and on 10 January 2018 to HMP Oakwood.

11. The Claimant has pleaded in her Particulars that:

    (i) While at HMP Stoke Heath, Mr Carr told healthcare staff that he had panic attacks and had been hearing voices and "seeing shapes"; and was prescribed diazepam to assist him in controlling his anger and agitation; and

    (ii) While at HMP Oakwood, on three occasions in February 2018, he was found under the influence of PSs, and on two of those occasions, officers felt it necessary to call a "Code Blue" (an alert indicating that a prisoner is unconscious or not breathing).

12. There is evidence suggesting that Mr Carr had a lengthy history of substance misuse and had used NPSs on multiple occasions at both Stoke Heath and Oakwood.

13. On 19 February 2018 Mr Carr was transferred to HMP Birmingham. On 27 February 2018 he assaulted a prison officer and was placed in the segregation unit.

14. The Claimant's pleaded case is that Mr Carr was "known on the wing at HMP Birmingham for taking illicit substances" (although he had also told Officer Andrew Bailey that "whilst he was not in custody, he had tried to get off 'Mamba' [a PS]"). In a segregation unit health screen, he stated that he had taken drugs when he was on the wing.

15. However, Mr Holland's statement indicated that Mr Carr had not been "recorded by any individual as being under the influence of an illicit substance" while at HMP Birmingham and that there was "no evidence to suggest that the prison officers or healthcare were [on] notice that he was taking illicit drugs in Segregation".

16. At some point after 8.35 pm on 29 March 2018 Mr Carr was given hot water by Officer Bailey and another officer. At around 9.30 to 9.40 pm Officer Bailey heard Mr Carr talking through his cell door to another prisoner.

17. At around 10.05 pm Officer Bailey checked Mr Carr through the door of the cell and saw him on the floor in the foetal position, lying on his side, with his face turned away from the cell door. The Claimant's pleaded case is that Officer Bailey formed the opinion that Mr Carr had taken Mamba and collapsed under its effects.

18. Officer Bailey did not call a Code Blue and instead continued his round of the segregation unit, checking on the rest of the prisoners. Approximately 5 minutes later, Officer Bailey returned to Mr Carr's cell to check on him again. He found him still lying on the floor in the same position. He kicked the cell door and shouted Mr Carr's name but received no response.

19. At around 10.10 pm Officer Bailey went to look for the Night Orderly Officer, Scott Plant, to get assistance to open the cell door. Officer Plant was in another cell on a different wing with the nurse. After concluding with that prisoner, Officer Bailey, Officer Plant and the nurse on duty on the wing, Sharon Kazmierowski, went to Mr Carr's cell and opened the door.

20. At about 10.23 pm Ms Kazmierowski observed that Mr Carr's lips were purple. She found no signs of life. CPR was commenced and an ambulance was requested. Mr Carr did not regain consciousness and was pronounced dead at 10.35 pm.

21. On investigation the police recovered a 24 foot rope from Mr Carr's cell that had been made from twisted sheets with a plastic bag attached to it. The Claimant's case is that the rope had been used by Mr Carr to receive drugs from another cell via the plumbing system.

22. On 4 April 2018 a post-mortem examination was carried out on Mr Carr's body. A toxicology report was prepared which identified the presence of the synthetic cannabinoid. The pathologist Dr Nicholas Hunt concluded that given the results of the toxicology analysis, and in the absence of any other factor capable of having caused his death, Mr Carr was likely to have died from the use of a synthetic cannabinoid.

The use of PSs and NPSs in HMP Birmingham prior to Mr Carr's death

23. Mr Holland's statement provided some contextual evidence about the emergence of NPSs within the prison estate. He quoted an HMCIP report from 2015 which indicated the following:

> "Synthetic cannabis (more specifically, 'Spice') was first identified to HMI Prisons as a serious problem in December 2011 at the inspection of HMP Standford Hill, but was not identified as a widespread issue until 2013 onwards. In the 2013-14 annual report [by HMCIP] synthetic cannabis was identified as a concern by HMI Prisons in a third (37%) of male prisons inspected, and this increased to 64% in 2014-15…
>
> …the availability of…NPS…particularly synthetic cannabis known as 'Spice' or 'Mamba', became highly prevalent during the preparation for this report. NPS have created significant additional harm and are now the most serious threat to the safety and security the prison system that our inspections identified".

24. On 17 April 2015, Dean Boland died while a serving prisoner at HMP Birmingham. The details of his death can be elicited from the judgment of Julian Knowles J on the civil claim brought by his mother: *G4S Care and Justice Services Limited v Dawn Luke (Suing on behalf of and as Administrator of the Estate of Dean Boland* [2019] EWHC 1648 (QB).

25. Post-mortem evidence showed that eight drugs were found in Mr Boland's system, two of which had been prescribed to him, while six had not been so prescribed or were illicit. One of these was 'Black Mamba' or 'Mamba': *Luke* at [13]. The jury at the inquest into Mr Boland's death ultimately accepted the evidence given in the post-mortem report, to

the effect that the cause of his death was 'mixed drug toxicity': *Luke* at [13]-[14]. However, Mr Holland's evidence was that "[t]he role of PS in Mr Boland's death is not clear". He quoted the pathology evidence to the effect that 'Black Mamba can be associated with cardiac complications, but it is not clear if it contributed to Mr Boland's death". This chimes with the approach taken by Julian Knowles J: see [163] below.

26. The jury was also critical of the steps taken by the Defendant to reduce the ingress of illicit drugs into HMP Birmingham. The deficiencies were described as having facilitated "a culture of irresponsible drug use within the prison's drug detoxification facility": *Luke* at [14].

27. In the meantime, in July 2015, the Prison and Probation Ombudsman ("PPO") published a 'learning lessons bulletin' regarding NPSs. Mr Waite accepted that information from the PPO was provided to privately run prisons as well as those run directly by the state. The PPO introduced the bulletin by indicating that the precise health risks of NPSs were "difficult to establish" but that there was "emerging evidence that there are dangers to both physical and mental health, and there may in some cases be links to suicide or self-harm". Further, the PPO wrote:

> "I hope by sharing the lessons from the <u>few deaths where we know that use of NPS was a factor</u>, this will support efforts in prison to address the threats they pose and help educate prisoners about the risks involved" [my emphasis].

28. The report looked at 19 deaths in the prison estate between April 2012 and September 2014 where the prisoner was known or strongly suspected to have been using NPS type drugs. It focussed on their 'behaviour and health risks'. In one of the three prisoner case studies, a Mr 'A' had died from natural causes (a heart attack) hastened by the use of a synthetic cannabinoid. The bulletin set out five lessons to be learned, including that "Governors need to ensure that NPS are addressed by effective local drug supply reduction and violence reduction strategies".

29. On 23 September 2016 the PPO announced that the number of prison deaths in which PSs may have played a part had risen to at least 58. The announcement highlighted a risk to physical health as one of the four types of risk from NPS. It also identified five areas of learning. One was that "Supply needs to be reduced. Trafficking in NPS needs to be tackled by effective local drug supply and violence reduction strategies"; another that "staff awareness needs to be increased".

30. In February 2017 HM Chief Inspector of Prisons ("HMCIP") inspected HMP Birmingham. In the April 2017 report that followed the Inspector identified two key areas that needed to be addressed, the first of which was that:

> "…the safety and stability of the prison was clearly being adversely affected by the high volume of illicit drugs, particularly…NPS…which were available. Fifty per cent of prisoners told us it was easy to get drugs, and one in seven was acquiring a drug habit while in jail…the prison had a drug supply reduction strategy, and there was good partnership with West Midlands Police, but more needed to be done. In particular, and in common with other establishments, there needed to be an assessment as to whether

> the technology being used to counter the threats posed by drones, mobile telephones and prisoners concealing drugs internally was both the best available and being effectively used".

31. As at March 2018 an 'initial screening tool' used by the Drug and Alcohol Recovery Team ("DART") at HMP Birmingham warned prisoners that the effects of NPSs can include "increased heart rate…..anxiety, paranoia, behaving out of character, memory loss or DEATH" (emphasis in the original) and that "People are dying" from using PSs. Mr Carr signed such a form on 20 February 2018.

The July/August 2018 HMCIP inspection and events thereafter

32. Between 30 July 2018 and 9 August 2018, HMCIP conducted an unannounced inspection at HMP Birmingham. This led HMCIP to invoke the 'Urgent Notification' process on 16 August 2022, writing to the Minister for Justice to express serious concerns about the manner in which the prison was being operated.

33. HMCIP's letter dated 16 August 2018 included the following:

> "*Drugs*
>
> We saw many prisoners under the influence of drugs and the smell of cannabis and other burning substances pervaded many parts of the prison. Testing suggested a third of prisoners were using illicit drugs and half the population thought drugs were easy to obtain. One in seven said they had developed a problem with illicit drugs since they had been in Birmingham. Our own observations confirmed to us that the use and trafficking of illegal substances was blatant. I have inspected many prisons where drugs are a problem, but nowhere else have I felt physically affected by the drugs in the atmosphere - an atmosphere in which it is clearly unsafe for prison staff to live and work. In light of this, it was shocking that many staff did not seem to be prepared to tackle the drugs misuse. When inspectors at one point raised the fact that drugs were clearly being smoked on the wing, the response from staff was to shrug.
>
> We were made aware during the inspection of the recent death of three prisoners and although the circumstances were still subject to investigation by police and the [PPO], it was likely that misuse of synthetic cannabinoids was involved".

34. The letter concluded:

> "I was astounded that HMP Birmingham had been allowed to deteriorate so dramatically over the 18 months since the last inspection. A factor in my decision to invoke the Urgent Notification procedure is that at present I can have no confidence in the ability of the prison to make improvements. There has clearly been an abject failure of contract management and delivery…

> In my view…there can be little hope that matters will improve until there has been a thorough and independent assessment of how and why the contract between government and [the Defendant] has failed…
>
> The inertia that seems to have gripped both those monitoring the contract and delivering it on the ground has led to one of Britain's leading jails slipping into a state of crisis that is remarkable even by the low standards we have seen all too frequently in recent years….
>
> …there is an urgent and pressing need to address the squalor, violence, prevalence of drugs and looming lack of control that currently afflict HMP Birmingham".

35. As a result, the Ministry of Justice directed that HM Prison and Probation Service ("HMPPS") take over the operation of HMP Birmingham. Paul Newton, former Governor of HMP Swaleside, was appointed as a replacement Governor for HMP Birmingham.

36. The full report provided by HMCIP after the inspection, in September 2018, said:

> "…Put simply, the treatment of prisoners and the conditions in which they were held at Birmingham were among the worst we have seen in recent years…we found an institution that was fundamentally unsafe, where many prisoners and staff lived and worked in fear, where drug taking was barely concealed, delinquency was rife and where individuals could behave badly with near impunity".

37. Further, the HMCIP report said the following in respect of drugs:

> "One in two prisoners said that it was easy to get illicit drugs at the prison, and health services staff had attended 311 incidents related to the use of [NPSs] in the previous six months.
>
> …Drugs were too easily available…We witnessed many prisoners under the influence of drugs and some openly using and trafficking drugs around the prison. Incidents involving [NPSs] were routine and we often smelt cannabis on the wings. Shockingly, staff were too often ambivalent and accepting of such incidents…".

The PPO investigation and report

38. The PPO team conducted a series of interviews in May-June 2018, the transcripts of which were appended to Mr Holland's statement.

39. In his statement Mr Holland highlighted the evidence given in interview by Officer Bailey to the effect that he was aware of the potential for the prison's sewage system to be used in some manner to transport drugs, but had not experienced any specific case where this had occurred.

40. Pages 9-10 of the transcript of Officer Bailey's interview reflect him explaining that he was aware that prisoners "had got a way of doing something with the toilet system…they could get drugs passed down, or passed across to each other through the toilet system"; "[o]bviously that was something that we'd heard of"; this was called "piping"; the first time he had heard of this was while working on the segregation unit; but he did not know the specifics of how it worked.

41. Mr Holland also referred to the interview evidence of Natalie Logan (Head of Security), to the effect that "it would not be straightforward to transport drugs in that manner".

42. Pages 23-27 of the transcript of Ms Logan's interview indicate her saying "of course" it was possible to circulate drugs into the segregation unit through the toilet system, using a method called "piping"; it was "not rocket science"; it was "effectively just a pulley system"; "it's not easy to get it right, but once it's been achieved it's very difficult for us"; it had to operate from the landings above because gravity played a part in the system; and that "it's not an easy thing to do".

43. The PPO report noted that the prison was undertaking a number of measures to tackle the problem of PSs, including search dogs, cell searches, processing mail and using fabric checks to look for illicit items in cells or suspicious behaviour of prisoners. It noted that HMP Birmingham had a drug strategy in place and that staff were working hard to implement it. However, it concluded that in light of the HMCIP report it was "clear…that more needs to be done to reduce both the supply and the demand for PS".

44. In respect of the pulley system through the sewage pipes, through which it was understood Mr Carr had obtained PSs in the segregation unit, the PPO noted that it would be expensive and impractical to redesign or replace the piping. The PPO recommended that the Governor commission an appropriately skilled person to review and address the risks posed by the sewage system, to prevent illicit substances being moved around the prison.

The inquest

45. In January 2019 the inquest into Mr Carr's death took place. A full transcript of the evidence was not provided to me, but both parties referred to aspects of the evidence heard.

46. The Claimant's Particulars quote the evidence of the new Governor of HMP Birmingham, Mr Newton, to the effect that the prison had reached the poor state it was in by "a lack of basic procedures" which included "minimising and attempting to minimise the ingress of substances into HMP Birmingham". He had referred to staff being inexperienced and the need for a more robust management response. It is pleaded that when asked specifically whether sufficient steps had been taken to address the ingress of illicit substances he replied "I have to answer no to that".

47. The Claimant's Particulars assert that (i) evidence given at the inquest indicated that the Defendant was aware that prisoners used the prison's plumbing system as a method to transport drugs between landings; (ii) this had been known by the Defendant for a considerable period of time; and (iii) no steps had been taken to address or minimise the problem.

48. Ms Gallwey's statement referred to the inquest evidence of Officer Bailey to the effect that that he had known about the method of transporting drugs through the plumbing for around five years. He said that this has been "fed back to the Security Manager then but I never heard back about it."

49. Ms Gallwey also quoted the inquest evidence of Laura Lowe to the effect that senior staff at the prison were aware that drugs were being distributed via the plumbing but that she had not known this, despite her position as Head of Safer Custody. According to Ms Gallwey, she acknowledged this was a "pretty terrible breakdown in communication".

50. Mr Holland's statement referred to the inquest evidence of Ms Logan, to the effect that transporting drugs through the plumbing system was "not an easy thing to do"; further that it "has to be coordinated with a number of prisoners involved working simultaneously". She had also explained that it was not possible to change the piping system due to its age and the infrastructure of the building. Ms Gallwey's statement said that this was a selective quotation of Ms Logan's evidence. She highlighted that Ms Logan had also agreed that the 2018 HMCIP report was an accurate reflection of the situation at the prison and confirmed that she had been aware of the use of the plumbing system to convey drugs for some time. Although Ms Logan gave evidence that there was no "intelligence" on this issue, Ms Gallwey's statement indicated that DI Marsh gave evidence to the inquest to the effect that there was.

51. The jury's narrative conclusion of the inquest included the following paragraph:

> "At the time Birmingham prison was facing a serious problem with the ingress of drugs. It is clear that this problem was not being adequately controlled. We do not feel that any intelligence was recorded appropriately in order to understand the full extent of the serious drug problem within the prison at the time. Through the evidence we have gathered it is apparent that there has been no action taken to reduce the risks of using the plumbing system to send and receive drugs".

The Preventing Further Deaths report and the Defendant's response

52. On 31 January 2019, the Coroner issued a Preventing Further Deaths ("PFD") report under paragraph 7, Schedule 6 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. This set out three "matters of concern". The Defendant responded to this report by letter dated 12 April 2019.

53. First, the Coroner expressed concern that according to the evidence at the inquest, before his transfer to Birmingham prison on 19 February 2018, Mr Carr had been involved in four incidents of taking PSs, resulting in a Code Blue being called. In addition there was intelligence that he may be giving out drugs. This information was available and passed on to HMP Birmingham, but they were not aware of it and did not record the information. The inquest had heard that there was no time to review information about prisoners coming into the prison. The Coroner described this as a "major concern" because "key information may not be identified and this poses a risk to the individual and other prisoners".

54. The Defendant's response noted that HMPPS was now running HMP Birmingham, and that in January 2019 the prison had reviewed the systems it had in place to access, obtain and record intelligence information about prisoners being transferred into the establishment. The letter stated that security teams now routinely applied for temporary access to a prisoner security file prior to their arrival and that a notice had also been sent to staff to remind them of the requirement to review the documents when a prisoner arrived at the prison, to identify the prisoner's needs and assess what risk, if any, they posed to themselves and others.

55. Second, the Coroner expressed concern that it had been known for approximately five years that drugs and other items could be passed through the plumbing system of the prison, but no action had been taken to address this before Mr Carr's death. The inquest had heard that no solution to the problem had been found. The Coroner was concerned that this raised an ongoing concern for the wellbeing of prisoners and the risk of future deaths.

56. The Defendant's response stated that the distribution of drugs through the plumbing system was "not a prevalent method used by prisoners" and that "[t]here was no intelligence at the Prison at the time of Mr Carr's death to suggest this method was being used". It was said that due to the integrity of the structure of the prison and the fact that the plumbing system ran in straight lines, there were no structural changes that could be made.

57. However, the Defendant explained that in January 2019 a Dedicated Search Team ("DST") had been established to conduct intelligence-led searches. They were trained among other things to look out for signs of the plumbing system being used to distribute drugs. They had specialist equipment allowing them to see beyond the U-bend of a toilet, to ensure no items had been concealed.

58. Third, the Coroner indicated that many problems within the prison relating to substance misuse were contributed to by the use of contraband mobile phones. The Defendant's response indicated that due to the location of the prison it was not possible to block mobile phone signals. However, the present Governor was working closely with national and local crime agencies; and the prison was using various pieces of equipment to tackle the use of mobile phones in the prison, including a metal detector.

Further aspects of the evidence

59. Mr Holland stated that at the time of Mr Carr's death, the availability of NPSs posed a serious challenge to all local prisons with a similar profile to HMP Birmingham. The PPO had recognised that HMP Birmingham was not alone in facing the problem of NPSs, which was a serious problem across the prison estate.

60. Mr Holland referred to evidence suggesting that five such prisons were "comparable to (and in some cases worse than)…HMP Birmingham", measured by random mandatory drug testing, the development of drug dependency within the prison and the perception of prisoners as to the ease with which drugs could be accessed. Ms Gallwey suggested that Mr Holland's evidence in this respect was a somewhat selective interpretation, as levels of testing will vary, and in any event, all of these prisons were inspected after the Urgent Notification procedure in this case.

61. Mr Holland's statement indicated that to the best of the Defendant's knowledge there had been no other death in HMP Birmingham involving the use of drugs transported through the sewage system and it was "at the very least, an unusual method of transporting drugs which required a high degree of determination and planning". He provided further detail on Mr Boland's death, as summarised above, and referred to the deaths of two other prisoners.

62. The first, Mr H, had been found dead in his cell on 26 March 2018. He had died from a coronary artery thrombosis (a blood clot in the heart). The combined effects of PS and codeine were said to be contributing factors. K-wing, where he had died, is a general population wing. Mr Holland indicated that it was not clear which method of supply Mr H had used to gain possession of PS, but there was no evidence to suggest that it was the plumbing system.

63. The second, Mr B, had died of multiple organ failure on 31 March 2018. This was caused by sepsis arising from an infected intravenous drug injection site. Mr Holland said that Mr B had used Class A drugs in the community and it was believed that he had used a PS several days before his incarceration. There was no suggestion that he had used PS while detained at HMP Birmingham.

64. Mr Holland confirmed that the prison had acted on the PPO's recommendation and put in place additional precautions to guard against the misuse of the sewage system.

65. According to the Defendant's 12 April 2018 letter, it was mutually agreed with the Ministry of Justice that the transfer of control of HMP Birmingham from the Defendant to HMPPS would be permanent with effect from 1 July 2019.

66. Mr Holland also summarised the statutory scheme governing the operation of prisons in England and Wales, provided further detail about how the contract for the Defendant to run HMP Birmingham operated and about the urgent notification process.

67. He also responded to each of the alleged breaches of duty pleaded by the Claimant. He provided various iterations of HMP Birmingham's drug reduction policies.

68. Ms Gallwey's statement indicated that the Claimant took issue with Mr Holland's interpretation of the evidence exhibited to his statement. She asserted that in many places it was not consistent with the evidence of the Defendant's own witnesses at the inquest into Mr Carr's death. She provided a series of examples of this in her witness statement, as noted in various respects above, albeit making the point that it was not appropriate to seek to resolve such factual disputes on a strike out or summary judgment application.

The Claimant's claim

69. The Claimant's case is that at the time of Mr Carr's death, the Defendant (i) was or ought to have been aware that the ingress of illicit drugs into HMP Birmingham posed a foreseeable risk of harm to prisoners including a risk of death; and (ii) did or ought to have appreciated that urgent and significant steps were required to reduce the ingress of illicit substances such as PSs.

70. She asserts that the Defendant was subject to:

    (i) The Article 2 general duty, which involved a duty to take reasonable measures designed to reduce the availability and use within the prison of illicit drugs such as PSs which pose a substantial risk to life; and/or

    (ii) The Article 2 operational duty, because the Defendant was aware of a real and immediate risk to Mr Carr's life, and thus was required to take those measures within the scope of its powers which, judged reasonably, might be expected to avoid that risk.

71. At paragraph 7 of her Particulars of Claim, she contends that these duties were breached, because the Defendant, in particular, had failed at the material time to:

    (i) Develop and implement an adequate drug supply reduction strategy and action plan;

    (ii) Take reasonable measures which would have significantly reduced the ingress of drugs, such as photocopying letters to prevent the ingress of drugs soaked into paper correspondence;

    (iii) Utilise technological solutions such as scanning of prisoners and visitors;

    (iv) Take steps designed to limit the ability of prisoners to transport drugs around the prison by use of the plumbing system;

    (v) Ensure that staff confronted illicit drug use including by making sufficient use of the adjudication system; and

    (vi) Implement CCTV within the prison.

72. Further, she alleges that in all the circumstances, the Defendant permitted a culture to develop in which illicit drugs were used by prisoners blatantly with impunity. The consequence was that vulnerable prisoners such as Mr Carr were detained in an environment in which they were surrounded by illicit and dangerous substances which posed a risk to their life.

73. The Claimant asserts that there is a real prospect or substantial chance that reasonable measures designed to reduce the availability and use within the prison of illicit drugs which posed substantial risks to life would have resulted in a different outcome, in particular Mr Carr not dying in March 2018.

74. She seeks declaratory relief and compensation by way of just satisfaction under Article 2.

The legal framework

The powers to strike out and grant summary judgment

75. Under CPR 3.42(a), a court may strike out a claim as disclosing no reasonable grounds for bringing the claim.

76. Under CPR 24.2(a)(i) and (b) a court may grant summary judgment on the grounds that the claim has no reasonable prospects of success and that there is no other compelling reason why it should be disposed of at trial.

77. The legal principles to be applied on a strike out/summary judgment application are uncontroversial. They were helpfully summarised in *Luke* at [19] as follows:

    (i) The court must consider whether the Claimant has a 'real' as opposed to a 'fanciful' prospect of success: *Swain v Hillman* [2001] 1 All ER 91;

    (ii) A real claim is one that is more than merely arguable: *ED&F Man Liquid Products v Patel* [2003] EWCA Civ 472 at [8];

    (iii) In reaching its conclusion the court must not conduct a mini-trial: *Swain*, supra,

    (iv) This does not mean that a court must take at face value everything that a claimant says in statements before the court. In some cases it may be clear that there is no real substance in factual assertions made, particularly if contradicted by contemporaneous documents: *ED&F Man Liquid Products v Patel* [2002] EWCA Civ 1550 at [10];

    (v) However, in reaching its conclusion the court must take into account not only the evidence actually placed before it on the application for summary judgment, but the evidence that can reasonably be expected to be available at trial: *Royal Brompton Hospital NHS Trust v Hammond (No 5)* [2001] EWCA Civ 550; and

    (vi) Although a case may turn out at trial not to be really complicated, it does not follow that it should be decided without the fuller investigation into the facts at trial than is possible or permissible on a summary judgment hearing. Thus the court should hesitate about making a final decision without a trial, even when there is no obvious conflict of fact at the time of the application, where reasonable grounds exist for believing that a fuller investigation into the facts of the case would add to or alter the evidence available to a trial judge and so affect the outcome of the case: *Doncaster Pharmaceuticals Group Ltd v Bolton Pharmaceutical 100 Ltd* [2007] FSR 3.

78. Mr Jacobs for the Claimant also drew support from *Standard Bank Plc v Matt International Ltd* [2013] EWCA (Civ) 490 at [17] for the proposition that the purpose of CPR 24 is to "to enable the court to dispose summarily of cases that are fanciful, hopeless or bound to fail, not to conduct an abbreviated form of trial on the basis of incomplete evidence".

The general and operational duties under Article 2

79. In *Rabone v Pennine Care NHS Foundation Trust* [2012] 2 AC 72 at [93]-[94] Baroness Hale explained that the first sentence of Article 2, to the effect that "Everyone's right to life shall be protected by law", imposes three distinct obligations upon the state.

The third is a positive obligation to protect life. This has two aspects: (i) a general duty to have in place laws and a legal system which deter threats to life from any quarter and punish the perpetrators or compensates the victims if deterrence fails; and (ii) an obligation to take positive steps to prevent a real and immediate risk to the life of a person in a recognised category of particularly vulnerable people from materialising. The latter is often referred to as the "operational" duty.

80. The general duty was described by Lord Rodger in *Mitchell v Glasgow City Council* [2009] 1 AC 874 at [66] thus:

> "…The obligation of the United Kingdom under article 2 goes wider, however. In particular, where a State has assumed responsibility for an individual, whether by taking him into custody, by imprisoning him, detaining him under mental health legislation, or conscripting him into the armed forces, the State assumes responsibility for that individual's safety. So in these circumstances police authorities, prison authorities, health authorities and the armed forces are all subject to positive obligations to protect the lives of those in their care. The authorities must therefore take general measures to employ and train competent staff and to adopt appropriate systems of work that will protect the lives of the people for whose welfare they have made themselves responsible. These are general obligations, not directed at any particular individual, but designed to protect all those in the authorities' care. If, however, an authority fails to fulfil one of these obligations and someone in their care dies as a result, there will be a violation of his or her article 2 Convention rights".

81. The operational duty was summarised in *R (Kent County Council) v HM Coroner for the County of Kent* [2012] EWHC 2768 (Admin) (Foskett J and the Chief Coroner) at [41] thus:

> "….where there is an allegation that the authorities have violated their positive general duty to protect the right to life, it must be established that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk: *Osman v United Kingdom* (2000) 29 EHRR 245; *Mitchell v Glasgow City Council* above; *Watts v United Kingdom* (2010) 51 EHRR 66 at paras. 82-83; *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2."

82. In the HRA:

(i) Section 6(1) makes it unlawful for a public authority to act in a way which is incompatible with a Convention right;

(ii) Section 6(3)(b) provides that a "public authority" for these purposes includes "any person certain of whose functions are functions of a public nature"; and

(iii) Section 6(5) provides that "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".

The issues and the parties' positions in overview

83. The application gives rise to the following issues:

Issue (1): Has the Claimant properly pleaded the alleged breaches of the general duty against this Defendant rather than the Secretary of State for Justice?

Issue (2): Does the Claimant have a real prospect of establishing at trial that the matters pleaded at paragraph 7 of the Particulars fall within the scope of the general duty as a matter of principle and that they were breaches of that duty?

Issue (3): Does the Claimant have a real prospect of establishing at trial that with adequate measures designed to reduce the ingress of illicit drugs, there would have been a real prospect of Mr Carr's death being avoided?

Issue (4): Does the Claimant have a real prospect of establishing at trial that there was a breach of the operational duty?

84. Mr Jacobs submitted that Issue (1) involved issues of fact and law, but Issues (2)-(4) were entirely factual matters, which were wholly inappropriate for resolution on an application for strike out or summary judgment. He described it as a striking feature of the evidence in support of the application that the Defendant had not sought to present the court with a factual account of what actually happened within HMP Birmingham. No Defence had been provided or indications given of which facts were admitted or denied. Ms Gallwey's evidence made clear that there were a series of factual issues in the evidence. Overall, he submitted that there was an inadequate basis upon which to base findings in support of an application for strike out and summary judgment.

85. Mr Waite submitted that the evidence and issues were such that the claim was capable of determination by strike out or summary judgment.

Issue (1): Has the Claimant properly pleaded the alleged breaches of the general duty against this Defendant rather than the Secretary of State for Justice?

The Defendant's submissions

86. Mr Waite relied on four key points in support of his assertion that the general duty under Article 2 in the prison context is owed by the Secretary of State for Justice alone and not a private contractor.

87. First, the nature and scope of the general duty under Article 2 indicates that it is owed by the state: see, for example, the quotation from *Mitchell* at [66], cited at [80] above, referring to the state having assumed responsibility for a prisoner by taking them into custody, and thus assuming responsibility for their safety and owing a positive obligation to protect their lives. There was a practical and moral responsibility on the state in this context, which did not apply to a private contractor. An allegation of a breach of the general duty must be judged with reference to the totality of the measures which the state has put in place to safeguard life in a relevant context, including national policies and procedures. It is therefore clear that the general duty falls upon the state and not a private body responsible for implementing one aspect of the system.

88. Second, the nature and scope of the statutory regime applicable to UK prisons is incompatible with the imposition of a general duty on a private contractor. For example, the Secretary of State has the "general superintendence" of prisons under the Prisons Act 1952, section 4(1); and a broad power under section 47 thereof to make "rules for the regulation and management of prisons" and for the "classification, treatment, employment, discipline and control" of prisoners. This power has generated a body of rules, orders and instructions and a policy framework which covers every aspect of prison life and apply to all prisons. Although the Secretary of State has the power under the Criminal Justice Act 1991, section 84(1) to contract with a third party to run a prison, they are required to appoint a crown servant as "controller" of the prison and can replace the Prison Director (who holds the position of Governor) in certain circumstances. These provisions are a manifestation of, rather than a derogation from, the general superintendence of prisons which the Secretary of State is required to exercise.

89. Third, the degree of control exercised by the Ministry of Justice ("MoJ") in relation to HMP Birmingham, and the confines within which the Defendant was required to operate, were incompatible with the imposition of a general duty on the Defendant. Mr Waite referred to a National Audit Office ("NAO") briefing which described (i) the permanent presence on site of the MoJ controller and assistant and deputy comptrollers, whose task is to enforce contractual implementation at an operational level and who are overseen by a dedicated team of civil servants within the MoJ who are responsible for the oversight of privately operated prisons; (ii) the process for the identification of areas of concern within a private prison by the MoJ, including the power of the MoJ to issue improvement and rectification notices; (iii) the fact that the contract performance regime involves a series of targets in areas such as drug testing, cell searches and prisoner complaints, with financial deductions being made in the event of non-compliance; and (iv) the fact that, unless the contract specified otherwise, it was the MoJ who would "normally fund and specify projects to upgrade existing facilities".

90. Fourth, the wider public interest overwhelmingly favours the Secretary of State being held accountable for a breach of the general duty, given (i) the need for the department which is responsible for devising, funding and controlling the prison system to be held accountable for alleged deficiencies in that system; (ii) the potential for the protection afforded by Article 2 to be undermined should a state be entitled to rely upon the actions of a private body as a means of evading its responsibilities to safeguard the lives of prisoners; and (iii) the fact that as the MoJ has knowledge of the entire prison system, it understands the implications for the wider prison estate of taking or not taking a step in a particular area and the cost to the public of doing so, whereas private contractors have a much more limited power to remedy general deficiencies, particular where issues are said to be linked to cost and resources. Accordingly it is more workable and sensible for the Secretary of State to be solely responsible for any breach of the general duty. By contrast, there is no apparent public interest in requiring private providers to be subject to the general duty: the Secretary of State has rights to seek an indemnity under the contract for any breaches by such providers.

91. In response to Mr Jacobs' submissions on section 6(3)(b) of the HRA, Mr Waite submitted that section 6 does not assist the court in deciding what functions under the HRA are in fact delegable. Nothing in section 6 is capable of conferring upon a private contractor a duty which can only be discharged by the state.

92. *Watling v Chief Constable of Suffolk Constabulary* [2020] RTR 23 was a claim for breaches of Articles 3 and 8 brought against a Chief Constable and G4S Health Services (UK) Ltd, to whom the provision of healthcare in the police custody suites had been outsourced. At [66]-[70] Judge Saggerson (sitting as a judge of the High Court) found that in this context G4S was carrying out a public function, because there had been a contractual assumption of responsibility for the delivery of a significant public service to a vulnerable section of the community (namely detainees) which was publicly funded; and that none of the acts in question were private, as they were "so intricately intertwined with the public function that it [was] unreal to regard them as private acts within a public framework". On that basis G4S was a public authority for the purposes of the HRA claim. Mr Waite submitted that the status of the Defendant under the HRA was not fully argued in *Watling*. He emphasised that *Watling* was not a decision on the Article 2 general duty and argued that the police custody context was different from the prison setting.

93. By further written submissions after the hearing Mr Waite drew an analogy with *Woodland v Swimming Teachers Association and another* [2014] AC 537. At [23] of *Woodland*, Lord Sumption set out the criteria for determining whether a tortious duty of care is delegable. Mr Waite argued that each one applies to this context: (i) prisoners are especially vulnerable or dependant on the protection of the state against the risk of injury; (ii) there is an antecedent relationship between the parties as the state has assumed responsibility under Article 2 for the protection of the prisoner's life; (iii) a prisoner has no control over how the state chooses to perform those obligations, whether personally or through employees or third parties; (iv) the state had delegated to a third party a function which was an integral part of the positive duty which it had assumed to the claimant; and (v) the third party was alleged to have been negligent not in some collateral respect but in the performance of the core function delegated to them by the state, namely the running of a safe prison. At [25], Lord Sumption indicated that it was also relevant to consider whether it would be just and equitable to hold that the duty in question was non-delegable. That militated in favour of the general Article 2 duty being non-delegable.

94. In *GB v Home Office* [2015] EWHC 819 (QB) Coulson J (as he then was) applied the ruling of the Supreme Court in *Woodland* to the custodial setting, holding that the Home Office owed a non-delegable duty of care in respect of medical treatment to a detainee at an immigration removal centre.

95. Mr Waite submitted that *Woodland* and *GB* should be applied to lead to the conclusion that the Article 2 general duty was also non-delegable because (i) there is no Strasburg jurisprudence which assists with the delegation issue; (ii) a breach of the HRA constitutes a breach of a statutory tort; and (iii) consistency of approach as between the common law and the HRA was desirable, in the absence of any countervailing reason public policy.

The Claimant's submissions

96. Mr Jacobs submitted that the difficulty with the Defendant's submissions was that they ignored the provisions of the HRA, section 6(3)(b). The intention of Parliament was plainly that those who perform public functions are subject to the same duties as "core" public authorities. Operating a prison is a function of a public nature. This is consistent with the approach taken and the finding in *Watling*. While this did not decide the precise issue

in this case about the Article 2 general duty, it came very close to resolving the issue in the Claimant's favour.

97. The Defendant's argument that section 6(3)(b) only applies to delegable public functions has no basis in authority and is an attempt to read something into the HRA which is simply not there. Parliament could have chosen to implement certain exceptions to section 6(3)(b), such as that the Secretary of State retained sole responsibility under the HRA for prisons, but had not done so.

98. The responsibilities for complying with the general duty would inevitably be shared between the Secretary of State and the contractor: the former would likely remain responsible for matters of law, policy, and funding, with the latter responsible for many aspects of the implementation of general measures, under contractual arrangements. However where an aspect of the general duty has been contracted to the private contractor, there is no reason why a claim in respect of the violation should only be aimed at the state, and not at the private contractor: that is the effect of s.6(3)(b). While the Secretary of State exercises a degree of control over a private contractor, such that a claim might also have been brought against the Secretary of State, this does not absolve the contractor of their own obligations, or mean a claim cannot be brought against them.

99. There is a clear public interest in being able to hold a private contractor to account for failures to perform its contractual obligations in a manner consistent with the general duties imposed by Article 2, as section 6(3)(b) reflects. To require a claim to be brought against the Secretary of State and not the private contractor would (i) require the state to incur additional and unnecessary cost in respect of a failure for which it is not materially culpable; (ii) create litigation in which the relevant knowledge and disclosure is held not by the defendant; and (iii) protect the private contractor from the accountability required by s.6(3) of the Act.

100. *Woodland* and *GB* are of no assistance because they relate to delegable duties of care in tort which are a creature of the common law. This is not a common law claim, but a claim for violation of the HRA, such that section 6(3)(b) is determinative. The court cannot develop section 6 in the same way that courts may develop the common law.

101. As to the argument about the desirability of consistency between the common law and the approach under the HRA, the courts have frequently recognised that the scope of liability at common law and pursuant to the HRA often differ, and for good reason (see, for example, *Michael v Chief Constable of South Wales Police* [2015] UKSC 2 at [125]-[127]).

102. Mr Jacobs also noted that in *Razumas v Ministry of Justice* [2018] EWHC 215 Cockerill J declined to find that the MoJ could be liable under Article 3 for alleged failures in medical care provided in a prison. At [236] she held that the breaches complained of were:

> "…essentially medical matters…[relating] to pain, to lack of medical information and lack of therapeutic strategy. These are not even affected by custody. The failures were healthcare failures and the correct defendants to this claim…are prima facie the relevant healthcare entities".

103. In any event, he submitted that whether a particular measure is one contracted out to the private contractor, or one for which responsibility rests with the State is a question of fact. It was notable that Mr Holland's evidence detailed what the Secretary of State's obligations were, without providing comparable detail on the Defendant's own obligations and how they related to the breaches alleged by the Claimant.

104. The evidence that was available illustrated, for example, that (i) the Defendant's Prison Director had "responsibility for day-to-day delivery of the custodial service, supported by a management team and some 300 custodial staff"; (ii) the Defendant was responsible for ensuring a sufficient number of staff with the requisite level of skill and experience were engaged at the prison, to ensure that it was a "safe, secure and decent environment"; and (iii) the Defendant was responsible for "planned and reactive maintenance and repair of existing facilities", and might need to raise with the Secretary of State the need for asset replacement or upgrade, and asked to contribute to the cost. Whether any of the alleged breaches related to issues of cost for which the Secretary of State was responsible (and some clearly did not) were issues that could not be determined on a summary basis.

Analysis and conclusion

105. Having considered the competing submissions I have concluded that it would not be appropriate to allow the Defendant's application for strike out or summary judgment by reason of Issue (1) for two overarching reasons.

106. First, I consider that as a matter of law, the Claimant has reasonable grounds for bringing the claim against this Defendant and a real prospect of satisfying the trial judge that this claim is properly so advanced.

107. In my view there is force in Mr Jacobs' submission that whether or not a claim might also lie against the Secretary of State is irrelevant. On that analysis, the arguments and evidence about the level of control the Secretary of State has over private prisons merely indicate that a second claim may lie against the Secretary of State, but do not mean that a claim cannot also lie against this Defendant.

108. On any view section 6(3) is a central provision in this case. I consider that the Claimant has a real prospect of showing at trial that it is the only relevant provision and that operating a prison, as the Defendant did, is a public function for the purposes of the section. While *Watling* is not determinative, the Claimant has a real prospect of showing that the approach taken by HHJ Saggerson should apply here, and that the attempts to distinguish it by the Defendant (summarised at [92] above) are not persuasive.

109. The Defendant's position implicitly advanced the proposition that the general duty under Article 2 in the prison context is to be treated differently to the operational duty or other duties under the HRA, in that there is something unique in its nature and scope that means it cannot be delegated. In my view the Claimant has real prospects of showing the trial judge that there is no basis for such a distinction, given the absence of any such "carve out" in section 6(3) for the general duty under Article 2 or for prisons.

110. If section 6(3) is determinative, then arguments about where the public interest suggests the duty should lie do not arise, as Parliament has resolved the issue. However, to the

extent that the trial judge considers the public interest relevant, there are competing arguments on both sides, and the Claimant has real prospects that hers will succeed.

111. Further, I consider that the Claimant has a real prospect of satisfying the trial judge that there is no basis for importing the tortious, common law approach to non-delegability evident in *Woodland* and *GB* into the separate and distinct statutory scheme of the HRA.

112. Second, the authorities reiterate that the court should not conduct a mini-trial on an application of this nature and must have regard to the further evidence that is likely to be available at trial. It is not appropriate to seek to determine factual disputes on the basis of a partial evidential picture.

113. Here, the evidence currently available does not address the specifics of the contractual relationship between the Secretary of State and the Defendant. For example, the NAO briefing on which Mr Waite placed considerable reliance provides a helpful overview of how the arrangements worked in general, but does not assist with the granularity of responsibility for each of the breaches of the Particulars of Claim. There is no direct evidence before me from any employee of the Defendant and the solicitors' evidence necessarily quotes the findings or evidence of others. As Ms Gallwey's statement illustrated in various respects that the interpretation of that evidence is controversial between the parties.

114. Based on the evidence currently available, the Claimant has real prospects of showing that at least some of the breaches pleaded at paragraph 7 fell within the Defendant's areas of responsibility. For example, the drug supply strategies and action plans had all been designed by the Defendant. The Claimant thus has real prospects of showing at trial that any failures in this regard were the Defendant's. Managing the staff was the Defendant's responsibility. She therefore also has real prospects of showing at trial that the Defendant was responsible for any failure of the staff to use the adjudication system against prisoners involved in illicit drug use.

115. However, where responsibility properly lies for the other breaches alleged at paragraph 7 is more fact sensitive. The trial judge is likely to have much more evidence available about the precise contractual arrangements between the Secretary of State and the Defendant on these issues. The same applies to evidence about any negotiations that took place on issues such as the provision of photocopiers, scanners and CCTV and other measures aimed at reducing the ingress of drugs into the prison and the transporting of drugs around it through the plumbing system.

116. These factual uncertainties provide a further reason why I do not consider that Issue (1) justifies a strike out or summary judgment in the Defendant's favour.

Issue (2): Does the Claimant have a real prospect of establishing at trial that the matters pleaded at paragraph 7 of the Particulars fall within the scope of the general duty as a matter of principle and that they were breaches of that duty?

The issue of principle regarding the alleged breaches of duty

117. Mr Waite argued that none of the matters pleaded were of a nature or quality that were capable of establishing a breach of the Article 2 general duty.

118. He highlighted that there is no domestic law precedent for concluding that the general duty is owed in the context of the consumption of drugs in prison. *R (Scarfe) v Governor of HMP Woodhill* [2017] EWHC 1194 (Admin) appears to be the only decision in which a UK court has considered an allegation of a breach of the general duty in the context of a UK prison, but this involved self-inflicted deaths.

119. The Strasbourg cases relied upon by the Claimant do not assist her either: *Eremiasova and Pechova v Czech Republic*, no. 23944/04, 16 February 2012 and *Keller v Russia*, no. 26824/04, 17 October 2013 were concerned with elementary physical safeguards related to the preservation of life; and although *Marro and others v Italy*, no. 29100/07, 30 April 2014 involved the prevalence of drugs in the Italian prison, the court held the claim to be manifestly ill-founded.

120. Mr Jacobs responded that the general duty for which the Claimant contends, namely a duty to take reasonable measures designed to reduce the availability and use of illicit drugs, such as PSs, which pose a substantial risk to life is derived from and consistent with first principles. As *Mitchell* at [66] (see [80] above) made clear, the general duty (i) arises where the state has assumed responsibility for an individual, including by taking them into custody; (ii) imposes an obligation to have in place appropriate systems of work that will preserve the lives of those for whom they are responsible; and (iii) is not directed at any particular individual, but at the prison population generally.

121. Examples of the general duty in the authorities include (i) the "general precaution" of "wire netting which, for well over a century, has been stretched between the first floor landings of traditional British prisons to catch prisoners who might try to commit suicide by jumping from an upper landing" (*Savage v South Essex Partnership NHS Foundation Trust* [2009] 1 AC 681 at [30], per Lord Rodger); (ii) the provision of suitable facilities, staffing and systems of operation for the ambulance service (*R (on the application of Humberstone) v Legal Services Commission* [2011] 1 WLR 1460 at [58]); and (iii) the system of supervision or appointment of police officers (*D v Commissioner of the Metropolis* [2018] UKSC 11, [2019] AC 196 at [96]). It is therefore evident that the general duty extends beyond the requirement for a legal and policy framework, but includes the implementation of practical, general measures, precisely of the kind addressed by paragraph 7 of the Particulars.

122. Further, although *Marro* was declared inadmissible on its specific facts, the Court held that the state was under "a duty to adopt anti-drug trafficking measures, especially where this problem (potentially) affects a secure place such as a prison" and thus it assisted the Claimant.

123. Mr Jacobs submitted that the Claimant has real prospects of showing at trial that the Defendant knew that PSs were a particular type of drug which posed a risk of death, not merely harm, to prisoners, and the Defendant knew this. He relied in particular, on (i) the July 2015 PPO learning lessons bulletin which shared lessons about " deaths where we know that use of NPS was a factor"; (ii) the September 2016 PPO announcement that the number of prison deaths in which PSs may have played a part had risen to at least 58; and (iii) the DART initial screening tool, signed by Mr Carr in February 2018 at HMP Birmingham, which noted the risk of "DEATH" (emphasis in the original) and that "People are dying" from using PSs (see [27]-[29] and [31] above).

124. I consider that the Claimant has real prospects of showing at trial that the matters relied upon are capable of falling within the Article 2 general duty. For the reasons advanced by Mr Jacobs, the duty contended for is derived from and consistent with first principles about the nature of the general duty on the state to detained prisoners and the need to take steps to preserve their lives. *Marro* is specific authority for the proposition that the general duty can extend to a duty to implement anti-drug measures. Finally, there is at present an evidential basis for the proposition that not only did PSs pose a risk of death, but that the Defendant knew this at the material time (see the evidence summarised at [123] above). For these reasons I do not consider it appropriate to strike out the claim or grant the Defendant summary judgment on it by reason of this first element of Issue (2).

The issues of detail regarding the alleged breaches of duty

125. The second overarching point taken by Mr Waite under Issue (2) in reliance on Mr Holland's evidence was that none of the matters relied upon at paragraph 7 of the Particulars disclose an arguable breach of the general duty.

126. Mr Jacobs' global response was that none of the alleged breaches were susceptible to strike out or summary judgment because the Defendant had provided no pleaded position; the evidence remained incomplete; and it was simply not possible to make findings at this stage as to what the general duty required in this context. The exceptional use of the Urgent Notification procedure and the robust criticism of the HMCIP was sufficient to show that the Claimant had a real prospect of success on the breach of duty issue.

127. I accept Mr Jacobs' general submission as to the preliminary state of the evidence. It is apparent from Ms Gallwey's evidence that the factual context is far from agreed. It is nevertheless necessary to consider the position with respect to each of the pleaded breaches separately.

<u>Paragraph 7(a): Alleged failure to develop and implement an adequate drug supply reduction strategy and action plan</u>

128. Mr Waite emphasised that the Defendant's plan was approved by the MoJ. However, in my view Mr Jacobs is correct to argue that the MoJ's approval of the plan does not necessarily mean he cannot prove at trial that it was inadequate.

129. Mr Waite also asserted that the Defendant's plan was only criticised in one HMCIP report, that of 2018.

130. However, Ms Gallwey's statement highlighted that (i) the 2017 HMCIP report had noted that the monthly drug and alcohol strategy committee meetings were "poorly attended" and "did not focus on implementing supply and demand reduction"; and (ii) the 2018 report was very critical, to the effect that although there was a strategy and action plan in place "many important actions had not yet been achieved or did not feature in the plan at all".

131. She also referred to the robust criticism made of the Defendant by HMCIP in the Urgent Notification process, the concessions made at the inquest by Mr Newton, the terms of the jury's narrative conclusion and the concerns raised by the Coroner in the PFD process,

all suggesting that the Claimant has real prospects of showing a failure of the Defendant's strategy and action plan at trial.

132. These are all points that the Claimant will no doubt take at trial to counter the Defendant's argument to the effect that the extent of the criticism made of the Defendant in this regard is one HMCIP report.

133. In light of these points I consider that, on the evidence currently available, the Claimant has real prospects of success on this issue at trial such that strike out or summary determination is inappropriate.

Paragraph 7(b): Alleged failure to take reasonable measures which would have significantly reduced the ingress of drugs, such as photocopying letters to prevent the ingress of drugs soaked into paper correspondence

134. Mr Waite argued that for the Defendant to respond to the recent phenomenon of "soaking" correspondence, even legally privileged 'Rule 39' correspondence, with PSs would have "technological, resource and legal implications" and that the Defendant's actions in this regard had not been the subject of criticism by HMCIP.

135. Ms Gallwey's statement quoted Mr Newton's inquest evidence to the effect that (i) drug-soaked letters had been identified as a route for drugs coming into the prison; (ii) this could have been addressed before Mr Carr's death; and (iii) photocopying letters had significantly reduced the ingress of drugs into the prison.

136. Overall, whether or not the use of a photocopier would have been reasonable prior to Mr Carr's death, whether the 'Rapiscanners' described by Mr Holland as being deployed in April 2018 should have been introduced earlier and the extent to which the Defendant appropriately sought funding from the MoJ for additional mail scanning equipment are all factual disputes that cannot be resolved at this stage. In light of Mr Newton's evidence it cannot be said at this stage that the Claimant does not have real prospects of succeeding in this allegation.

Paragraph 7(c): Alleged failure to utilise technological solutions such as scanning of prisoners and visitors

137. Mr Waite relied on Mr Holland's evidence to the effect that electronic body scanners were only introduced into UK prisons in 2018 and HMP Birmingham was not selected for participation in the pilot that year, such that they were not introduced into the prison until May 2019. He also noted that the Defendant had unsuccessfully sought funding from the MoJ for the replacement of the Victorian windows at the prison.

138. On the face of it, this evidence appears to provide at least a partial answer to the Claimant's pleaded case on this issue. On balance, though, I consider that these issues will be more fully explored at trial, including by evidence directly from the Defendant. This may well address whether and why the Defendant was solely reliant on the MoJ for the implementation of scanners; whether the funding in relation to the windows was appropriately sought; and whether there were other measures open to the Defendant which were not adopted. Further evidence on issues such as these could well place Mr

Holland's evidence in a different context, such that I consider strike out or summary judgment premature.

Paragraph 7(d): Alleged failure to take steps designed to limit the ability of prisoners to transport drugs around the prison by use of the plumbing system

139. Mr Holland's evidence to the effect that the prison was not in receipt of intelligence prior to Mr Carr's death that the sewage system was a prevalent method of use for the transportation of drugs is directly contradicted by Ms Gallwey's account that DI Marsh told the inquest that there was such intelligence (see [50] above).

140. There is also wider evidence suggesting knowledge within the prison of the use of the plumbing system to transport drugs: see (i) the accounts given by Officer Bailey and Natalie Logan to the PPO (see [39]-[42] above); and (ii) the evidence given by Officer Bailey, Ms Logan and Ms Lowe to the inquest (see [48]-[50] above). This evidence was reflected in the jury's narrative conclusion and the Senior Coroner's finding in the PFD report that this had been known for approximately five years (see [51] and [55] above).

141. The evidence at trial is likely to explain the Defendant's position that it was not possible to adjust the plumbing system, what investigations the Defendant undertook in this regard and with what result. There may well also be greater clarity at trial as to whether it would have been reasonable for the Defendant to have taken the steps with respect to the plumbing system that were taken after Mr Carr's death, described at [57] and [64] above, any earlier. Strike out of or summary judgment on this pleaded allegation is therefore not appropriate.

Paragraph 7(e): Alleged failure to ensure that staff confronted illicit drug use, including by making sufficient use of the adjudication system

142. Mr Waite referred to the finding in the 2018 HMCIP report to the effect that the number of adjudications had risen, and that most of these were for possession of illicit substances and positive drug tests.

143. However, HMCIP's observations about staff "shrugging" in response to the inspector's suggestion that that drugs were clearly being smoked on the wing; that staff were "too often ambivalent and accepting of such incidents"; that drug use was "barely concealed"; and that prisoners were using drugs with "near impunity" (see [33], [36] and [37] above) mean that further evidence at trial is likely to put the adjudication figures in their full context. Again, strike out or summary judgment is inappropriate.

Paragraph 7(f): Alleged failure to implement CCTV within the prison

144. Mr Waite relied on Mr Holland's evidence and the NAO briefing to the effect that the Defendant had sought funding for the installation of CCTV but this had not been forthcoming as of 2018. As Mr Jacobs highlighted this limited material gives no detail of when the difficulties with the CCTV first arose, and when steps were taken to seek funding. Again, it is appropriate that this issue is properly explored at trial.

Paragraph 7(g): Allegation that in all the circumstances, the Defendant permitted a culture to develop in which illicit drugs were used by prisoners blatantly and with impunity

145. Mr Waite submitted that this pleading "overstates" the contents of the HMCIP report and that the phenomenon of "barely concealed" drug taking was a "short term" one, that did not feature in the 2014, 2017 or 2019 inspections, with the latter noting that inspectors no longer observed overt drug use on the wings.

146. Mr Jacobs' response was that the full HMCIP report and the Urgent Notification process in 2018 speak for themselves; and the fact that the phenomenon had alleviated by the time of the following inspection in 2019 supports the argument that it was not an inevitable consequence of the challenge of drugs in prison, but a consequence of the Defendant's specific failings, which were remedied once the prison was taken over by HMPPS.

147. In light of the evidence currently available, including the full HMCIP report and the urgent notification correspondence, I consider that the Claimant has real prospects of succeeding in this issue at trial.

148. For all these reasons I do not consider that Issue (2) justifies a strike out or summary judgment in the Defendant's favour.

Issue (3): Does the Claimant have a real prospect of establishing at trial that with adequate measures designed to reduce the ingress of illicit drugs, there would have been a real prospect of Mr Carr's death being avoided?

The issue of principle regarding causation

149. The parties agreed that in *Daniel and another v St George's Healthcare NHS Trust and another* [2016] 4 WLR 32, it was held that the causation test in this context is whether a failure to take reasonably available measures could have had a "real prospect" or "substantial chance" of altering the outcome.

150. However, Mr Jacobs submitted that establishing the element of causation is not necessary for the purposes of establishing a violation of Article 2, and, therefore, the Claimant succeeding in her claim, albeit that it might be relevant to the amount of damages. He based his submission on *Griffiths and others v The Chief Constable of Suffolk Police* [2018] EWHC 1538 (QB) at [557], per Ouseley J, thus:

> "In *Van Colle*, at [104], in a passage relied on by Mr Johnson, the Strasbourg Court considered the applicants' contention that had DC Ridley arrested Brougham on witness intimidation charges, the death might have been avoided. But it said that as there was no real and immediate risk to his life, the argument amounted to a "but for" test of state responsibility, which was not the correct test. I accept, following *Sarjantson v Chief Constable of Humberside* [2014] QB 411 that compliance with Article 2 should not be determined with the benefit of hindsight; the fact that it may be proved, after the event, that measures reasonably to be taken in the light of the "real risk of an imminent threat to life", would not have been effective does not mean that no breach of Article 2 in fact arose. Effectiveness or otherwise is relevant to damages. The reference in [28] to *Kilic* explains the thinking: a state cannot excuse itself for a failure to take what, without hindsight, is a reasonable step at the time on the basis that, with hindsight, it would not have been effective. That could permit states to fail to do what they

> reasonably could have done, and to argue about it afterwards, when it was too late. It is no answer to an alleged breach of Article 2 to say, prospectively, that the step, though reasonable, and one which could have succeeded, would probably have failed; its reasonableness must depend in part on its potential, viewed at the time of the decision and not with hindsight, to prevent or contribute to preventing death or to reducing risk" [my emphasis].

151. Mr Waite responded by referring to *E v UK* [2003] EHRR 31 at [99], where the Strasbourg court held that:

> "A failure to take reasonably available measures which could have had a real prospect of altering the outcome or mitigating the harm is sufficient to engage the responsibility of the State".

152. Although *E* related to Article 3 duties, Mr Waite submitted that it suggests that the requirement for there to have been a real prospect of altering the outcome applies to liability and not quantum: the words "engage the responsibility" in this passage can only relate to liability, which would be consistent with *Van Colle*. To the extent that there is a conflict between the above position and the decision of the Court of Appeal in *Sarjantson*, Mr Waite argued that the Court should apply *E* and *Van Colle*.

153. Mr Jacobs submitted that it is not entirely clear whether the observation in *E* is directed at the issue of causation and quantum, or to liability. However, this court should prefer the more recent, domestic authority which is directly on point and binding, namely *Sarjantson* as applied in *Griffiths*.

154. This issue was only the subject of relatively brief argument before me due to the time taken with addressing the other issues. The trial judge will no doubt hear more detailed legal submissions on it. However, for present purposes I consider that the Claimant has real prospects of satisfying the trial judge that *Sarjantson* is the applicable authority, and thus that causation is not a necessary element of her claim for declaratory relief, even if it is relevant to her claim for damages.

The issue of evidence regarding causation

155. Mr Waite submitted that there was no evidential basis for the argument that Mr Carr's death was caused or contributed to by the matters which form the basis of the alleged breaches, applying the *Daniel* test. He relied on the fact that Mr Carr was in the segregation unit. He submitted that he obtained drugs through a "highly unusual" method, namely the plumbing system. It was therefore inherently speculative to try and draw a causal connection between the problem of drugs in the prison and the use of the plumbing system to obtain drugs.

156. Mr Jacobs responded by arguing that as a matter of logic, if HMP Birmingham had not been "awash with PSs" there would have been a real prospect of a different outcome. It will be a matter for the trial judge to assess whether reasonably available measures would have reduced the availability of drugs within the prison. Specifically, the Claimant has real prospects of showing at trial that the risk of prisoners transporting drugs via the plumbing system was known by the Defendant; and that if steps had been taken to reduce

those risks, it is likely that there would have been no means to pass drugs to Mr Carr when he was in segregation, and he would not have died. In fact, Mr Jacobs contended, that would readily satisfy a balance of probabilities test, let alone a "real prospect" test.

157. Again, I prefer Mr Jacobs' submissions on this issue and accept that the Claimant has real prospects of satisfying the *Daniel* test at trial for the reasons he gave. This is especially so given that she has real prospects of showing at trial that the Defendant was aware of the risks of the use of the plumbing system to transport drugs: see [139]-[140] above.

158. For these reasons I do not consider that Issue (3) justifies a strike out or summary judgment for the Defendant.

Issue (4): Does the Claimant have a real prospect of establishing at trial that there was a breach of the operational duty?

Luke

159. Mr Waite's submissions on Issue (4) were heavily reliant on the decision of Julian Knowles J in *Luke*. It is therefore necessary to consider the judgment in some detail. As indicated at [24]-[25] above, *Luke* was a claim brought by the mother of Dean Boland, who had died from mixed drugs toxicity at HMP Birmingham on 17 April 2015. The sole claim was for breach of the operational duty under Article 2. The County Court judge dismissed the Defendant's application for strike out and/or summary judgment. Julian Knowles J allowed the Defendant's appeal and ordered summary judgment on the claim because he concluded that the Claimant did not have a realistic prospect of showing that there was a real and immediate risk to Mr Boland's life, of which the Defendant was or should have been aware, so as to trigger the operational duty.

160. The Claimant's case in *Luke* as to why there was a real and immediate risk to Mr Boland's life of which the Defendant was or should have been aware relied on the following non-exhaustive list of factors: (i) he was a vulnerable individual by the mere fact of being a detainee in the prison; (ii) at the time of his entry into the prison, he was known to be a drug addict, the Defendant's employees and/or agents having decided to treat him as such following his initial screening; (iii) the Defendant had various policies in place which sought to ensure that individuals who were addicted to drugs or other substances were screened and provided with appropriate treatment whilst at prison; (iv) the Defendant was fully aware of the risk to life that was posed to detainees through the abuse of both prescribed and illicit drugs, these risks being recognised in its drug and alcohol strategy; and (v) the Defendant provided training to prison officers in relation to substance misuse and the dangers faced by detainees in respect of such misuse: *Luke* at [15].

161. The following legal principles relating to the operational duty reiterated in *Luke* are pertinent:

    (i) It has been consistently emphasised in the authorities that the "real and immediate" risk test is a stringent test that is not an easy one to satisfy; it imposes a very high threshold which is a higher threshold than establishing mere negligence (see, for example, *Van Colle v Chief Constable of Hertfordshire Police* [2009] 1 AC 225 at [30], [69] and [115], per Lord Bingham, Lord Hope

and Lord Brown, *Re Officer L* [2007] 1 WLR 2135 at [20], per Lord Carswell and *Rabone* at [36]-[37], per Lord Dyson): *Luke* at [71]-[73];

(ii) The risk must be a risk to life: a risk of serious harm is not sufficient: see, for example, *Kent County Council*, cited at [81] above. In that case, the court accepted the argument of the local authority that there was no operational duty to take protective measures in relation to a vulnerable teenage boy, because there was no real or immediate risk to his life which the council knew about or ought to have known about. The council accepted that it was arguable that there was some risk of potential harm to the child, but that risk did not extend to a real and immediate risk to his life: *Luke* at [74]-[75];

(iii) Although in *Osman*, the Strasbourg court referred to an imminent risk to the life of an identified individual or individuals, later case law shows that the court has not limited the scope of the Article 2 duty to circumstances where the risk relates to the lives of identified individuals: it is sufficient if there is such a risk to a group of individuals which may include society at large: *Luke* at [76];

(iv) The *Osman* test requires the public authority to have known, or that it should have known, of the existence of the risk. As to this, guard must be taken against hindsight: what matters is what the public authority knew or ought to have known *at the time* (see *Van Colle* at [32], per Lord Bingham): *Luke* at [77]; and

(v) Where there is such a risk, then the standard demanded for the performance of the operational duty is one of reasonableness. This brings in "consideration of the circumstances of the case, the ease or difficulty of taking precautions and the resources available" (see *Re Officer L* at [21], per Lord Carswell): *Luke* at [78].

162. Julian Knowles J concluded that the judge was entitled to conclude that (i) illicit drugs such as Black Mamba were easily available on the wing where Mr Boland died; (ii) Buscopan (a prescription drug) was being misused by some prisoners to whom it had not been prescribed; (iii) prison staff had witnessed prisoners undergoing very unpleasant side effects such as hallucinations; and (iv) this fixed the Defendant with the knowledge that such drugs were being abused by some prisoners: *Luke* at [81]. He continued:

> "However, it is self-evident that misusing any drugs creates a risk to health. That is true even of common over-the-counter medications such as paracetamol and ibuprofen. But to conclude from this generalised risk of harm that there was a realistic prospect of the Claimant showing that misuse of these drugs carried a real risk of *death* paid insufficient regard to the fact that the *Osman* test is a stringent one which is not easily satisfied. A real risk of harm does not equate to a real risk of death as the court reasoned in the *Kent County Council* case. In short, I agree…that the judge did not apply the *Osman* test in a way which paid proper regard to the stringent nature": *Luke* at [81] [his emphasis].

163. He concluded that the judge had not been entitled to find that there was sufficient evidence to establish that the Defendant knew or ought to have known that the use of Buscopan, particularly with other drugs, might cause death: in fact the expert toxicology evidence was uncertain as to how the drugs in question interacted together: *Luke* at [81].

164. Ms Luke had sought leave to rely on fresh evidence, under the approach set out in *Ladd v Marshall* [1954] 1 WLR 1489. This evidence was said to show that the drugs situation at HMP Birmingham was bad, or had worsened since Mr Boland's death, and that in March 2018 there were four prisoner deaths, including one in which Black Mamba was involved: *Luke* at [56]. Julian Knowles J concluded that there was nothing in this fresh evidence to alter this conclusion. He readily accepted that it showed a "bad situation" in HMP Birmingham so far as the availability of drugs and other contraband items was concerned and that matters had not significantly improved since Mr Boland died. However the evidence did not provide much if any further support for the proposition that there was a real immediate risk to life from the use of these illicit drugs: *Luke* at [82].

165. Finally, he concluded that even if the judge had been correct to conclude that the use of Buscopan and Black Mamba with other drugs gave rise to a real and immediate risk of death, it was necessary to go on and consider whether there was sufficient evidence of a real and immediate risk to Mr Boland's life through the use of these drugs, of which the Defendant was, or should have been aware. The mere fact that drugs were available in the prison did not of itself give rise to the relevant risk and neither did the fact that Mr Boland was a long-term drug addict. To make such assumptions did not sufficiently recognise the stringent nature of the *Osman* test. On the evidence there were a series of factual matters which were not capable of being undermined that suggested that Mr Boland was "not at risk because it appeared that he had finally managed successfully not to take drugs for a sustained period and at the time of his death he had been drug free for some time": *Luke* at [83]-[87].

The parties' submissions

166. Mr Waite submitted that this case is weaker on its facts than *Luke* in at least one important respect: *Luke* was decided on the basis that illicit drugs such as Black Mamba were easily available on the wing where Mr Boland died, whereas Mr Carr died while he was in the segregation unit where he was unable to mix with other prisoners, having obtained drugs via the plumbing system. He submitted that the Claimant did not have reasonable prospects of demonstrating that the prison was on notice as to the existence of an immediate risk to life as opposed to harm.

167. In response, Mr Jacobs submitted that, as explained by the Supreme Court in *Rabone*, a real risk is simply one that is "substantial or significant" as opposed to remote or fanciful; and "immediate" means no more than present and continuing: see [38] and [40] per Lord Dyson.

168. The matters which the Claimant contended gave rise to the requisite level of knowledge by the Defendant were adequately pleaded in the Particulars of Claim, namely the Claimant's assertions that (i) on three occasions at HMP Oakwood in February 2018 Mr Carr had been found under the influence of PSs, and twice officers had felt it necessary to call a Code Blue (see [11(ii)] above); and (ii) he was known on the wing for taking illicit substances (see [14] above). He noted that the Defendant has not placed either of these pleaded contentions in issue.

169. He also placed reliance on the awareness more generally of the dangers of PSs, in particular because Mr Boland died in April 2015 and so before the July 2015 PPO

learning lessons bulletin, which is the first chronological document on which the Claimant relies as having alerted prisons to the link between PSs and death (see [27] above).

Analysis and conclusion

170. The summary of the pertinent legal principles at [161] above makes clear that a claim for breach of the operational duty faces significant legal difficulties. However, even allowing for the stringent nature of the requirements, and the high threshold in place, I am satisfied based on the currently available evidence that the Claimant has real prospects of distinguishing her case from *Luke* and succeeding on this issue at trial.

171. The first element of Julian Knowles J's reasoning in *Luke* was that there was insufficient evidence before the judge to justify the finding that the Defendant was aware of the risk to life caused by the use of Buscopan, particularly with other drugs, in particular given the uncertain toxicology evidence as to how the drugs interacted with each other: [162]-[163] above.

172. By contrast, I have already found that there is currently in this case a sufficient evidential basis for the proposition that not only did PSs pose a risk of death, but that the Defendant knew this at the material time (see [123]-[124] above).

173. Julian Knowles J considered the *Ladd v Marshall* evidence *de bene esse*. This apparently included reference to Mr Carr's death (as one of those that occurred in March 2018). However it is not clear whether this evidence included the reports and documents relied on by this Claimant and noted at [123] above).

174. The second element of his reasoning related to the insufficiency of evidence of a real and immediate risk to Mr Boland's life through the use of these particular drugs and the lack of knowledge by the Defendant of the same. He was not satisfied that Mr Boland's vulnerability as a prisoner and the fact that he was known to be a drug addict sufficed, not least given that the evidence suggested he been drug free for some time before his death (see [164] above).

175. However, this Claimant points to more specific and timely evidence about the Defendant's knowledge of Mr Carr's use of PSs, namely the three occasions in February 2018 Mr Carr when had been found under the influence of PSs, two of which necessitated a Code Blue. At trial it is likely that further evidence will make clear whether information about these events at HMP Oakwood was known by HMP Birmingham, and if not, whether it should have been.

176. The Claimant also relies on her pleaded case that Mr Carr was known at HMP Birmingham for taking illicit substances on the wing, and had stated this in the segregation health screen. Mr Holland's evidence appeared to challenge the level of knowledge within prison of Mr Carr's drug use, especially on the segregation unit (see [14]-[15] above). However it is not appropriate to seek to resolve this factual dispute on an application for strike out and/or summary judgment. There is certainly no contemporaneous documentation available to me which conclusively disproves the Claimant's pleaded case, such that resolving such a factual dispute at this stage might have been permissible.

177. I therefore decline to strike out the Claimant's claim or grant the Defendant summary judgment by reason of Issue (4).

Conclusion

178. Accordingly, for the reasons set out herein the Defendant's applications for strike out and/or summary judgment are dismissed.