

[2007–09 Gib LR 337]

**R. (Application of CHICHON) v. POLICE DISCIPLINARY BOARD**

SUPREME COURT (Dudley, Ag. C.J.): August 11th, 2009

*Police—disciplinary proceedings—judicial review—decision of Police Disciplinary Board unlawful if wrongfully dismisses charges against officers with respect to death of prisoner in custody—misapplication of test on no case to answer submission by prematurely making determinations on insufficient evidence and failing to consider whether case inherently weak on each charge—improper to express satisfaction at evidence exculpating officers*

*Administrative Law—judicial review—alternative remedies—in determining appropriate relief from unlawful decision, court to consider (i) delay in bringing challenge; (ii) sufficiency of applicant’s interest; and (iii) prejudice to either party—quashing of Police Disciplinary Board decision and remittal for re-hearing refused if public interest in disciplinary process investigating death in custody outweighed by prejudice to officers of second hearing—declaratory relief granted*

The applicant sought judicial review of a decision of the Police Disciplinary Board that four police officers had not been in neglect of their duties in relation to the death of his son while in custody.

The applicant’s son had been arrested when he had been found drunk in public and taken into custody, where several hours later he died as a result of acute alcohol intoxication. It was alleged that the four police officers on duty during the relevant period were in neglect of their duties for failing to rouse the deceased and seek medical attention, in accordance with policy and the training they had received, given his condition while in custody.

The investigations into the death of the deceased had been plagued by delay and the inquest was not concluded until over two years after his death. Nevertheless, charges were laid against the officers by the Royal Gibraltar Police (RGP) and considered by the Police Disciplinary Board. The Board examined evidence put forward by the RGP on whether the deceased had been unconscious and the extent of the duties on officers to supervise those in custody, including the requirement of “rousing” prisoners in custody, in the light of the relevant police guidelines and the training the officers had or had not received. The charges were dismissed following acceptance of submissions of no case to answer made on the officers’ behalf.

Four months later, the applicant applied to quash the Board’s decision on the grounds that (a) it had erred in law; (b) the decision was irrational as determinations had been made when there was no or inadequate evidence to support them; and (c) the proceedings were unfairly conducted, in the absence of a representative of the deceased, and tainted by bias as the chairperson had expressed satisfaction at evidence exculpatory of the officers. It was further submitted that the Board had erred in law by (i) considering the allegations too narrowly in failing to consider whether other rights of the deceased and duties on the officers had been breached; (ii) wrongly excluding evidence including the full investigatory report, as opposed to excerpts, and transcripts of interviews with the officers involved, which created the risk of inferences favourable to the officers being drawn on incomplete material; and (iii) misapplying the test on an application of no case to answer, with the consequence that the Board had wrongly dismissed the charges.

**Held**, granting declaratory relief but refusing a re-hearing:

(1) A declaration would be made that the Police Disciplinary Board had erred in law by accepting the no case to answer submissions and dismissing the charges. The Board had misdirected itself as to the applicable test when considering the no case to answer submissions. It had prematurely made determinations of fact (as to the state of the deceased and whether the officers were required to rouse him) and assessments as to the credibility of the witnesses when there was insufficient evidence to do so, especially as the officers had not then testified. It had thereby erred in determining whether the Board had proved its case at this stage and in not properly considering whether the case against each officer was inherently weak or whether there was in fact sufficient evidence to constitute a case to answer. Further, while the deceased’s son had been correctly excluded from attending the hearing as the proceedings were disciplinary, had been initiated by the RGP and were to be heard in private, the Board’s decision was also rendered unlawful by its improper conduct in expressing satisfaction at evidence favourable to the officers so that justice was not seen to be done (paras. 48–50; para. 59; para. 63; paras. 67–68; para. 77).

(2) In determining in its discretion the appropriate relief to be granted against the unlawful decision of the Board, the court would consider (i)

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any delay in bringing the challenge; (ii) the sufficiency of the applicant's interest; and (iii) whether either party would be substantially prejudiced by the granting or withholding of relief. The delay of four months in issuing a challenge to the Board's decision was excusable given the delays that had plagued the various stages of the investigation and proceedings—the inquest was not completed until over 2 years after the death of the deceased while disciplinary proceedings were not concluded until 3½ years afterwards. However, an order quashing the decision of the Board and remitting the matter for a re-hearing would not be granted since (a) it would provide no practical benefit to the applicant, only moral vindication; and (b) the public interest in a proper disciplinary process being conducted into a death in police custody was outweighed by the prejudice to the officers if there were to be a further disciplinary hearing six years after the death of the applicant's son. The deficiencies in the case presented were not the fault of the officers and it would be unfair to expose them to a second hearing, in which the RGP would have the advantage of improving its submissions. The appropriate remedy would therefore be a declaration recording the error of the Board (paras. 69–77).

**Cases cited:**

- (1) *D, In re*, [2003] N.I. 295; [2003] NICA 14, referred to.
- (2) *McBride (No. 2), In re*, [2003] N.I. 319; [2003] NICA 23, considered.
- (3) *R. v. Galbraith*, [1981] 1 W.L.R. 1039; [1981] 2 All E.R. 1060; [1981] Crim. L.R. 648; (1981), 73 Cr. App. R. 124, considered.
- (4) *R. v. Shippey*, [1988] Crim. L.R. 767, referred to.
- (5) *Reeves v. Metropolitan Police Commr.*, [2000] 1 A.C. 360; [1999] 3 W.L.R. 363; [1999] 3 All E.R. 897; [1999] Prison L.R. 99; (1999), 51 B.M.L.R. 155, referred to.

**Legislation construed:**

Police (Discipline) Regulations 1991 (L.N. 1991/090), reg. 4: The relevant terms of this regulation are set out at para. 7.  
Schedule 1, para. 4: The relevant terms of this paragraph are set out at para. 8.

*K. Azopardi* and *K. Navas* for the applicant;  
*H.K. Budhrani, Q.C.* for the respondent;  
*J.J. Neish, Q.C.* for Sgt. M. Ignacio and Const. N. Edwards, the first and third interested parties;  
*D.J.V. Dumas, Q.C.* for Sgt. F. Field, the second interested party;  
*M. Turnock* for Const. J. Barcio, the fourth interested party.

1 **DUDLEY, Ag. C.J.:** The claimant is the father of Mathew Chichon (“Mathew”) who died on August 30th, 2003 of acute alcohol intoxication whilst in the custody of the Royal Gibraltar Police (“RGP”). Mathew was, at the time of his death, 30 years of age, had a very significant criminal

record with some 70 current convictions, and had spent considerable time in prison. He had a history of drug and alcohol abuse and in August 2003 alone, he had been arrested on 9 separate occasions, 3 of those for drunkenness.

2 The judicial review arises from the decision of a disciplinary board (“the Board”), constituted pursuant to the provisions of the Police (Discipline) Regulations 1991, which dealt with a disciplinary hearing against four police officers (the interested parties), who following Mathew’s death were charged with counts alleging neglect of duty and which charges were dismissed following a submission of no case to answer.

3 The day after Mathew’s death, the then Commissioner of the RGP requested the assistance of the Metropolitan Police Service who provided an independent investigation team led by Det. Supt. Russell Penny, the head of the Metropolitan Police Specialist Investigation for the Internal Investigations Command, who took the role of Senior Investigating Officer. The conclusions of the final report produced by the Metropolitan Police team read:

“It is impossible to say whether or not Mathew Chichon would have died if he had not been in the custody of the RGP. It is clear that the lack of action by individual officers is likely to have contributed to his death. However, some responsibility must be borne corporately. The introduction of the training since the death of Clive Nunez [a death in custody in 2001] is commendable but there has been an absence of validation or supervision of the new processes and the personal failings identified were common, with little or no management grip or intervention apparent.”

4 The report then went on to recommend, *inter alia*, that the officers should be subjected to disciplinary proceedings and charged with wilfully neglecting to perform their duty whilst acting in a public office. The hearing of the disciplinary charges was, as I understand it, delayed pending the coroner’s inquest which concluded on December 12th, 2005 and in which the inquest jury found the cause of death as “acute alcohol intoxication” with the conclusion as to the death being “accidental death contributed to by neglect.”

5 At the behest of the Deputy Commissioner of the RGP, the following disciplinary charges were laid against the officers. In respect of Const. Edwards:

**“Statement of offence**

Neglect of duty contrary to reg. 4(a) of Schedule 1 to the Police (Discipline) Regulations 1991.

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**Particulars of offence**

On Saturday August 30th, 2003, you being a member of the Royal Gibraltar Police, at New Mole House police station, without good and sufficient cause, neglected or omitted to attend to or carry out with due and sufficient promptitude and diligence your duty as gaoler in that you failed to rouse Mathew Chichon on each cell visit between 12:50 and 13:30 in accordance with policy and training.”

6 The charge laid against Const. Barcio, the late shift gaoler, was in identical terms save that the time period in the particulars was 13:30 to 17:20. Sergeant Ignacio, the custody officer on the early shift, and Sgt. Field, the custody officer on the late shift, were also charged with neglect of duty contrary to the Police (Discipline) Regulations 1991 with the particulars of offence in respect of both officers being in identical terms, namely:

“(1) On Saturday August 30th, 2003, you being a member of the Royal Gibraltar Police at New Mole House police station, without good and sufficient cause, neglected or omitted to attend to or carry out with due promptitude and diligence your duty as custody sergeant in that you failed to ensure that Mathew Chichon was visited and roused in accordance with policy and training.

(2) On Saturday August 30th, 2003, you being a member of the Royal Gibraltar Police at New Mole House police station, without good and sufficient cause, neglected or omitted to attend to or carry out with due promptitude and diligence your duty as custody sergeant in that you failed to secure medical attention for Mathew Chichon in accordance with policy and training.”

7 The Police (Discipline) Regulations 1991 were made pursuant to s.52 of the Police Act 1961, which Act was incidentally repealed with effect from February 22nd, 2007, that is three days after the conclusion of the disciplinary proceedings. Relevant for present purposes is reg. 4(1), the terms of which are as follows:

“(a) A member of the Police Force commits an offence against discipline if he commits an offence set out in the Discipline Code contained in Schedule 1 hereto.

...

(g) The Disciplinary Code at paragraph 3 provides a good defence to a charge of disobedience to orders where an officer has ‘good and sufficient cause’ not to obey an order. Thus an officer does not commit this offence if his reason for failing to carry out an order was that he did not know of it and had a good reason for not knowing of it—for example, because it had not been properly communicated or promulgated.”

8 Paragraph 4 of Schedule 1 to the Regulations provides:

“Neglect of duty, which offence is committed where a member of the police force, without good and sufficient cause—

- (a) neglects or omits to attend to or carry out with due promptitude and diligence anything which it is his duty as a member of the police force to attend to or carry out . . .”

9 For the purposes of establishing before the Board the “policy and training” in the particulars of offence, the RGP sought to rely upon documents described as standing orders and Force orders. It is worth noting that by virtue of s.27 of the Police Act 1961 (repealed), the Commissioner could issue standing orders not inconsistent with the Act, *inter alia*, as to the duties to be performed by officers and to prevent neglect of duty. By virtue of sub-s. (2), any such standing orders were subject to approval by the Governor and had to be brought to the notice of every member of the force.

10 In 1966, standing orders duly approved by the Governor were put in place. A very substantial document, these were published as a book referred to as the “Blue Book.” Dealing with the inspection of prisoners, para. 8 of Part 10 of the 1966 standing orders provides:

“8. Prisoners will be visited at least once every hour and, if drunk, once every half hour. In the latter case they should be spoken to and aroused on each visit. A record of each visit will be made in the Occurrence Book.”

Also of some relevance are paras. 23–24 of Part 10 which provide:

“23. . . . When persons come into the hands of Police, whether as prisoners or otherwise and there is the slightest suspicion that they are ill or injured, the Station Officer is to be informed immediately and a doctor (Police Surgeon) sent for or the person removed to hospital, even if they make no complaint.

There must be no neglect in carrying out these instructions and a liberal interpretation should be placed on orders and instructions respecting the attendance of Police Surgeons in cases of illness, accident, injury or even of suspected injury or drunkenness.

24. Each officer who performs station duties must distinctly understand that he is expected . . . to make close personal investigations in each case and to exercise care and discretion with a view to the Surgeon being called whenever necessary.

Police are strictly cautioned to be very careful in conveying persons apparently drunk to stations. When a person in this condition

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is conveyed in a Police Van or placed in a cell, his head should be kept slightly raised by a canvas pillow.”

11 In 1991, standing orders were issued (“the 1991 Orders”). On the face of the document, it is unclear whether, as required by s.27(2) of the Act, these were approved by the Governor. In the section dealing with the welfare of detained persons at para. 106(o), it provides: “Cell occupants to be visited every hour, every half hour if drunk. Juveniles and those at risk more than once an hour.” It is noteworthy that, in contrast to the Blue Book, there is no stated requirement to rouse or indeed to raise the head with a canvas pillow.

12 Paragraph 107 of the 1991 Orders is also of some relevance. It provides:

“If a person brought to a Police Station or in detention

. . .

(c) Doesn’t show signs of sensibility and awareness or

(d) Otherwise appears to need medical attention,

the duty Doctor must be called immediately. This applies even if no complaint is made . . .”

13 On November 28th, 2002, Force orders were issued in connection with custody teams (“the 2002 Orders”). These were not, it would appear, standing orders approved by the Governor pursuant to s.27 of the Act. The evidence before the Board was, and it is not in dispute, that these came about as a consequence of the death in custody in 2001 of Mr. Nunez. The 2002 Orders provided that with effect from December 2nd, 2002, the concept of custody teams would be implemented for an initial three-month trial period. Updated job descriptions of, *inter alia*, the custody officer (sergeant) and the gaoler, setting out duties and responsibilities, were annexed to the 2002 Orders. As regards the custody officer, para. 3 of the job description provided that the role was “to ensure the welfare of all detained persons in accordance with regulations, procedures and policies at all times whilst they are the responsibility of the custody officer.”

14 As regards the gaoler, para. 5 of that job description provided that the role was “to look after the welfare of the detainee whilst in custody.” Both sets of job descriptions also include the rider that “the tasks described above are in addition to those expected of all police officers at this rank in the performance of their duties.”

15 Although the extent and adequacy of the training provided to the officers was a live issue before the Board, it is not in dispute that prior to the 2002 Orders coming into effect, the interested parties attended a two-day course in November 2002 in which they were provided with a

substantial document entitled “Custody Officers Training Manual” (hereinafter “the Manual”). It is of significance in the context of these proceedings that there is a passage to be found in the section entitled “Element C3—Ensure that the medical needs of the persons detained are met” and in which the aim of the section is stated to be “to enable the student to deal effectively with the medical needs of persons detained.”

16 It is useful to set out the passage extensively:

“The Custody Officer is responsible for the care and welfare of detained persons . . .

- The custody officer must immediately contact a police surgeon for any detained person who appears to need medical attention through illness, injury, and mental health or for any other reason . . . It is a principal responsibility of the custody officer.
- . . .
- Every detained person will be visited at least hourly . . .
- People who are intoxicated or suffering the effects of drugs will be observed to establish their level of consciousness. A person who is drunk shall be roused and spoken to on each visit.
- The term ‘roused’ is not defined. However, the Police Complaints Authority report ‘Deaths in Police Custody, Reducing the Risks’ makes the following recommendation . . . ‘*Custody staff should be required to enter the cell; shake the shoulder of the detained person; pose a direct question; take whatever action may be necessary in the light of the response, or lack of it; and record the whole matter on the custody record.*’
- If any detained person fails to meet any of the following criteria an appropriate health professional or an ambulance must be called.

When assessing the level of ‘rousability’ consider:

Rousability—can they be woken?

- Go into the cell.
- Call their name.
- Shake gently.

Response to questions—can they give appropriate answers to questions such as:

- What’s your name?
- Where do you live?



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- Where do you think you are?

Response to commands—can they respond appropriately to commands such as:

- Open your eyes!
- Lift one arm, now the other arm!

Remember to take into account the possibility or presence of other illness . . .”

**The evidence before the disciplinary board**

17 It is of course not for this court to make determinations of fact on the evidence which was before the Board. Rather, the role of this court is to consider whether, on the evidence which the Board had before it, it made determinations which it was reasonably entitled to reach and whether or not it fell into errors of law.

18 The evidence put before the Board by the presenter in support of the RGP’s case against the officers included read statements, live witnesses with video and audio recordings of activity in the custody area and Cell No. 1 during the relevant period. I have of course had the advantage of reading the transcript of the proceedings before the Board and of viewing relevant extracts of the video and audio recordings. Although unfortunately the quality of the audio is not as good as one could have hoped for, the events culminating in Mathew’s death are reasonably discernible and relatively uncontroversial.

19 At about 12:40 on August 30th, 2003, Const. Massey and Const. Ford received instructions via the police radio to attend the area of Garcia’s takeaway at Glacis Estate. On arrival, they found Mathew lying down on his front. The officers attempted to rouse him, he spoke to them in an incoherent manner, and they formed the opinion that he was under the influence of alcohol. He was arrested for the offence of being found drunk, he was assisted to the police van, and he was placed in the rear in the recovery position. He was conveyed to New Mole House and had to be physically carried out of the van into the station by both officers together with Const. Rodriguez who assisted by carrying Mathew’s legs.

20 A matter which was relied upon as being of some significance on behalf of the interested parties was that Mathew kicked out, making Const. Rodriguez lose his grip—as Const. Rodriguez put it in his evidence before the Board: “Not in a violent manner but obviously he must have realized that he was mid-air and was moving his legs.”

21 After being carried into the station at about 12:46, Mathew was taken into the custody area and into Cell No. 1 and placed in the recovery position on a mattress on the ground, which I understood to be standard

procedure to minimize the risk of injury through falling off the bench. According to the evidence given to the Board by Mr. Ford, who was no longer a police officer, at the time Mathew was taken into the station and placed in the cell he was not unconscious.

22 Present in the custody area were the first interested party, Sgt. Ignacio (the custody sergeant) and the third interested party, Const. Edwards (the gaoler) both on the early shift. It is apparent from the video recording played at the hearing before the Board and at the hearing of this application, that almost immediately after being placed in the recovery position, Mathew moved onto his front. Mathew also moved his arms down to his sides and then back up again in what was categorized by counsel for the interested parties, I think inaccurately, as the pulling up of his trousers. If that was Mathew's intention it was a failed attempt. Constable Edwards opened the custody record and, significantly, the first entry on the log of events, timed at 12:50, reads "placed in Cell No. 1—unconscious."

23 At 13:11, Const. Edwards entered the cell, observed Mathew and exited. Thereafter at 13:22 (or 13:27, there was an issue before the Board as to the exact timing of this visit), no doubt as part of the shift handover both Const. Edwards and the fourth interested party, Const. Barcio, the late shift gaoler, entered the cell. Constable Barcio spoke to Mathew. Detective Const. Houghton, an officer from the Metropolitan Police involved in the inquiry who had reviewed the video tapes described this event as "rousing." It is noteworthy that this was evidence tendered by the presenter and read to the Board by him as the Board viewed the video.

24 Thereafter, Const. Barcio checked Mathew not less than every half hour by either entering the cell and looking at him or, in one instance, looking at him from the cell doorway. At 15:21, Dr. Salem Fouda, the forensic medical examiner, attended New Mole House police station to examine another prisoner. Whilst there, he spoke to Sgt. Field but was not asked to examine Mathew.

25 At 16:15, Const. Barcio entered the cell with another prisoner, John Paul Cruz, and although the recording of the conversation between Const. Barcio and Mr. Cruz is garbled, Const. Barcio can be heard to say to Mr. Cruz in Spanish: "You check that he is OK." Mr. Cruz, who remained in the cell, called out Mathew's name on a number of occasions but did not obtain a response. Shortly thereafter, Mr. Cruz lay down next to Mathew. Of some significance is a conversation between Const. Barcio and Sgt. Field at 16:16 which although garbled, the word "*inconsciente*" ("unconscious" in the Spanish language) can be made out.

26 From around 16:30, periods of laboured breathing, apparently coming from Mathew, can be heard in the recording. At 17:13, Const. Barcio entered the cell, knelt beside Mathew, called his name and obtained no

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response. There is a flurry of activity and by 17:18, CPR and mouth to mouth was administered by two officers. The ambulance arrived at 17:19 and, after various attempts at CPR, Mathew was taken out on a stretcher at about 17:25. Following further attempts at resuscitation at St. Bernard's Hospital, Mathew was pronounced dead at 17:55.

27 The evidence of Dr. Jerreat, a consultant forensic pathologist who undertook a post-mortem examination on Mathew as to the cause of death, was that the post-mortem examination revealed—

“ . . . macroscopical, *i.e.* naked eye, and microscopical evidence of inhalation of stomach content. In addition there was an extremely high level of alcohol which even in one used to alcohol was in the toxic range and capable of causing death.”

28 In his opinion, the most likely mode of death was from inhalation of the stomach contents whilst Mathew's cough reflex was suppressed. Elaborating before the Board as to the suppression of the cough reflex, he had this to say:

“ . . . [D]epression of the cough reflex would result in the effects of excessive alcohol on the central nervous system which allowed the passage of stomach content into the lungs with no significant resistance. This would obstruct his airways and add to his breathing difficulties which result from the direct effects of a high blood alcohol in the brain . . . [I]f medical attention had been sought earlier then death could have been avoided. Appropriate monitoring would have assessed his airway, lessened the risk of inhalation and given respiratory aid if necessary. If a person who is known to have taken substantial alcohol and or drugs and is in an unconscious or semi-conscious state then it is vital to seek medical attention to assess the person's fitness to be kept in custody.”

Given Dr. Jerreat's unchallenged evidence as to the mode of Mathew's death, it is wholly apparent that just before his death Mathew must necessarily have been either in an unconscious or semi-conscious state.

29 The RGP also relied upon the evidence of Insp. Golt who was, in mid-2004, a police sergeant attached to the Criminal Justice Unit and who was tasked by the then Chief Insp. Yome, to undertake a disciplinary investigation. Notwithstanding that the RGP's case as presented before the Board was at least in part predicated on the 1966 Blue Book, curiously, in cross-examination, Insp. Golt said that he had never seen the 1966 policy.

30 Moreover, on the basis that he had undertaken the investigation 2½ years earlier, he could not recall specifically what guidelines, policies or procedures he had looked at in the context of the investigation. Opining on the use of the word “unconscious” in the entry in the log by Const. Edwards, he testified to the effect that, having viewed the video, he would

have described Mathew as “very drunk” but that, nonetheless, he would have called an ambulance, albeit that he accepted that at that time the ambulance crew would have refused to take a drunk person.

31 The Board who had the advantage of assessing Insp. Golt as a witness reached the following conclusion in its reasons:

“During testimony, Insp. Golt under cross-examination stated that in his own mind, the officers were guilty of the charges. His abilities as investigations officer were challenged and particularly if he had gone into the investigation with pre-conceived ideas as to the guilt of the officers. Throughout the testimony, he referred to the fact that his involvement with the case had been over 2½ years prior to giving evidence and his memory failed him. Inspector Golt admitted having spoken to a police witness days before the hearing and passing comments about the investigation and he further stated that Supt. Yome had not wanted to give a statement. This led the members of the Board to voice reservations about the quality of testimony from Insp. Golt.”

32 Although not all the misgivings by the Board are ones which I would necessarily share, they of course had the advantage of seeing the witness in person. As a reviewing court and with the benefit of the transcript, it cannot be said that, as is implicit in the reasons, the Board, in choosing to attach limited weight to Insp. Golt’s evidence, could be described as unreasonable or irrational.

33 Possibly the most significant witness before the Board as to the RGP’s training and policy was Chief Insp. Smith. Chief Insp. Smith was, prior to Mathew’s death, Deputy Commander of the Operations Division and had been tasked to arrange and conduct the custody officer training courses. A significant aspect of his evidence related to the initial training provided to the officers in relation to the new custody arrangements put in place by the 2002 Orders. According to Chief Insp. Smith, the course was held over two days and all participants were issued with a copy of the Manual. The time allotted to preventing deaths in custody was 45 minutes and no practical training as to what amounted to rousing was given because in his view it would have amounted to insulting the officers’ intelligence.

34 Other aspects of his evidence which were clearly material were taken account of by the Board which, in its reasons, said:

“According to Chief Insp. Smith, the 1966 policy as to the treatment of prisoners was still applicable today. However, evidence proved that he himself had produced a policy on this subject in 1991 which only stated that half-hourly checks were to be made. It was silent on rousing, indeed rousing was not a written requirement.

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During his testimony, Chief Insp. Smith stated that he had conducted dip sampling of custody records and was completely satisfied with his findings. He further declared that he had never seen the word 'roused' used on any custody record. This was not a word used by police officers locally."

35 Whilst the passages are drafted in neutral terms they highlight some of the inadequacies of the case presented by the RGP. In my view, it is apparent from the transcript of Chief Insp. Smith's evidence that he was confused or at least unable to provide satisfactory answers as to how the policy requiring "rousing" of individuals in custody had evolved and in particular could not properly explain how the 1991 document authored by him was an evolution of the 1966 Blue Book when the 1966 Blue Book required rousing and the 1991 standing orders did not.

36 Also of some significance was Chief Insp. Smith's evidence as to the dip sampling undertaken by him to ensure compliance with the new custody regime. It is somewhat surprising that if the rousing of drunk individuals in custody was an important aspect of the custody officers' duties, whether introduced by the 2002 Orders or a resurrection of the defunct 1966 Blue Book, that the word "rousing" should not have been seen by Chief Insp. Smith when undertaking dip sampling of custody records. His explanation that it was not a word used by officers locally could properly be considered as somewhat disingenuous. His reliance upon the words "checked and found correct" could not have assisted in confirming whether or not custody officers were in fact implementing the rousing regime.

37 Another aspect of Chief Insp. Smith's evidence of some relevance was that relating to his lack of knowledge as to whether or not the 2002 Orders were ratified after the initial three-month trial period. Premised presumably upon this testimony and the absence of any force orders extending or providing for indefinite implementation of the 2002 Orders, the Board in its report appears to have determined that after the initial three-month period the 2002 Orders were not in fact implemented.

38 In some contrast to Chief Insp. Smith's evidence, Supt. Penny, in cross-examination dealing with various reports produced by him and his team, confirmed that in a second interim report to the Commissioner, he expressed the view that—

"the attitudes and actions of the custody staff subject to this investigation seem to be commonplace throughout all of the custody staff . . . The investigation team have found no evidence of supervision of the custody sergeants and no supervision/quality control of the custody records."

39 Superintendent Penny was of the view, as I understand the transcript

of his evidence, that there had been a systemic failure in that there had been very poor supervision to ensure that the new process was adhered to and that “there was no clear standing instruction in place.” Nonetheless, he was also of the view that the officers had been trained and knew what was required of them when dealing with drunk prisoners. No doubt in reaching the view as to the officers’ understanding of what was required of them, Supt. Penny had the advantage of certain admissions said to have been made by the officers when interviewed in connection with a criminal investigation but which were not a part of the RGP’s case before the Board.

40 The presenter also called as a witness Sgt. George Field, the station officer on duty when Mathew was arrested and, coincidentally, the second interested party’s brother. According to him, he had also undertaken the custody officer course and he testified that “everything we learned in that course was how to fill up the new custody record. The rest we all knew by experience what we had to do.” When questioned by a member of the Board, he testified to the effect that during the training course which he attended, the rousing of drunk prisoners was not mentioned.

41 At the conclusion of the case for the RGP, counsel representing the officers made submissions of no case to answer. The Board acceded to the application at the time it was made (on February 19th, 2007) albeit the reasons for the decision are contained in a document which followed and which was signed by the members of the Board on diverse dates between March 19th and April 17th, 2007. The Board’s decision is challenged on three broad grounds:

- (i) Errors of law;
- (ii) Unreasonableness and irrationality; and
- (iii) Want of fairness—conduct and bias.

42 The submissions in respect of irrationality and errors of law are, to the extent that a review of the evidence is concerned, intertwined. I will deal with these two grounds in the following order:

- (i) Error in approach;
- (ii) Wrongly excluding evidence; and
- (iii) The misapplication of the test in *R. v. Galbraith (3)*/failing to give appropriate weight to evidence/reaching an irrational conclusion in respect of the application of no case to answer.

#### **Error in approach**

43 Mr. Azopardi complains that the Board adopted too narrow an approach when considering the allegation of neglect of duty. He submits,

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and there can, I think, be no issue with the proposition that the right to life protected by the Constitution may be engaged when a person detained by the police dies as indeed does the general duty of care at common law (see *Reeves v. Metropolitan Police Commr.* (5)). Mr. Azopardi is also right to say that implicit in the duty imposed upon the police force by s.4 of the Police Act (repealed) to guard offenders is the duty to take care of a person in custody. Flowing from these propositions, he submits that the Board failed to direct its mind to these rights and duties when considering the allegations of neglect of duty and that such an error is fundamental in nature.

44 Indeed, s.33(2)(b) of the Act defines offences by police officers as including a “failure to comply with the Act.” Therefore a failure to guard an offender in its wider sense could amount to an offence. It is apparent from its reasons that the Board focused on the various orders and their status. It may well have been desirable for the case against the officers to have been presented on the basis which Mr. Azopardi urges, but what cannot be ignored is that these were disciplinary proceedings which were adversarial in nature. In my view, it was not part of the Board’s role to make up for any deficiencies in the way the case may have been prosecuted or bolster the case against the officers by relying upon duties which may have been relevant but which did not form part of the case as presented on behalf of the RGP.

45 A narrower point taken by Mr. Azopardi relates to the Board’s reliance upon the “good and sufficient cause” defence contained in reg. 4(1)(g). In its decision, the Board relied upon that provision as a further basis for its decision. Mr. Azopardi submits that the regulation creates that defence in respect of “disobedience to orders” but not in respect of neglect of duty. It is in my view an artificial point, particularly as the Discipline Code, at para. 4 of Schedule 1 to the Regulations, which creates the offence of neglect of duty, specifically provides for “good and sufficient cause” as a defence. The better point, however, is that, the officers not having given evidence, it is difficult to understand what evidence the Board relied upon to find that that defence was made out.

**Exclusion of evidence**

46 Mr. Azopardi also criticizes the Board for failing to consider certain items of evidence, namely transcripts of the interviews given by the officers and Supt. Penny’s full report (as opposed to excerpts). It is apparent from the transcript that the RGP’s presenter formed the view, I think rightly, that the interviews given by the officers in connection with possible criminal proceedings were in fact not admissible for the purposes of disciplinary proceedings.

47 The presenter also agreed with the officers’ lawyers to place before

the Board excerpts of Supt. Penny's report as opposed to the full report. I share the concern that this created a real risk that the Board could draw inferences favourable to the officers on incomplete material. It is, however, apparent that these items of evidence were not excluded by the Board but rather were not relied upon by the presenter. The proceedings were adversarial rather than inquisitorial in nature and therefore in this regard no criticism can properly be levied against the Board.

**Submission of no case to answer, the misapplication of the test in *R. v. Galbraith* and irrationality**

48 *R. v. Galbraith* (3) establishes that a submission of no case succeeds where there is no evidence that the person charged had committed the crime and also where the evidence is so tenuous that the prosecution evidence taken at its highest is such that a jury properly directed could not convict. It was also held in that case that borderline cases fell for the exercise of the judge's discretion. The test applied by the Board upon the submission of no case to answer is to be found in the last page of its reasons where it says:

“The burden of proof rests with the Royal Gibraltar Police on every single element of the charge. The standard of proof must be beyond reasonable doubt. This case does not come up to proof and the Board felt that there was insufficient evidence for the matter to continue.”

It is, I think, self-evident from that passage that the Board misdirected itself.

49 The Board, moreover, compounded its error when considering the submission by making determinations of fact when there was no evidence before it upon which it could properly make those determinations and by prematurely embarking upon a final assessment of the credibility and reliability of the Force's witnesses. This can be illustrated by extracts from various passages in the report and findings. The Board appears to make the following finding:

“The custody record shows Const. Ignacio concluding that there is no known risk. This is a judgment call based on experience of the prisoner—the prisoner is conscious and suffers no injury and consequently there is no need for medical attention to be sought at this stage.”

50 It may in due course have possibly been open to the Board to determine that Mathew was conscious on arrival at the station premised upon Mr. Ford's evidence and the evidence of his kicking whilst being carried. The video evidence and indeed the entry in the custody record by Const. Edwards mentioned him being “unconscious” and yet the evidence of the mechanism leading to death indicated otherwise. For the purposes



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of this crucial issue, there was sufficient evidence for the *Galbraith* (3) hurdle to be overcome. In the report and findings, the Board makes the following finding: “According to testimony, no emphasis or indeed mention was made of the requirements to rouse drunken prisoners every half hour and thus the officers were ignorant of this requirement.”

51 The only evidence that the Board could rely upon to reach this conclusion was that of Sgt. George Field which, although from an RGP witness, was at odds with that of Chief Insp. Smith. Moreover, whether or not the training was adequate, the rousing requirement was nonetheless to be found in the Manual. It is also difficult to understand how the Board could make a finding that the officers were ignorant of the requirement when at that stage they had not testified and the interviews of the officers in connection with the disciplinary process had been essentially no comment interviews.

52 Explaining a delay in a half-hourly check by Const. Barcio, the Board determined that this was “due to the heavy work commitments of the custody team given the number of prisoners in cells.” With the officers not having testified and absent other cogent evidence in this regard, it is difficult to understand how this conclusion was reached. Dealing specifically with Const. Edwards, it made the finding that Mathew was placed in cells in the recovery position. Whilst strictly accurate, it is self-evident from the video that almost immediately Mathew lay on his front.

53 The Board also appears to have failed to take account of the conversation between Const. Barcio and Sgt. Frederick Field in which Const. Barcio, a minute after placing Mr. John Paul Cruz in the same cell as Mathew, is heard to say “*inconsciente*” (unconscious). Absent any evidence to the contrary, the *prima facie* inference to be drawn is that Const. Barcio was referring to Mathew. Dealing with Dr. Jerreat’s evidence, the Board in its report and findings quote him as stating:

“It is unfair to place such prisoners in cells as the custody teams are not medical practitioners . . . These officers could not have done anything to prevent this death . . . No matter how many checks you do you would not have prevented the death, indeed rousing would not have prevented the death . . . This person should not have been placed in cells but should have been taken to hospital and even there the death would have occurred.”

54 The words attributed to Dr. Jerreat were not specifically uttered by him but similar language can be found in his evidence, save as regards the final sentence in the above quote. In that regard, what Dr. Jerreat in effect said was that such a death could also have taken place in a hospital in the absence of proper monitoring. The Board also appear to have adopted a selective approach to his evidence. In examination-in-chief, Dr. Jerreat testified in the following terms:

“[I]n my opinion if medical attention had been sought earlier then death could have been avoided . . . if a person who is known to have taken substantial alcohol and/or drugs and was in an unconscious or semi-conscious state then it is vital to seek medical attention to assess the person’s fitness to be kept in custody.”

55 For my part what I essentially draw from the transcript of Dr. Jerreat’s evidence is that (i) there is a very significant risk of keeping a conscious or semi-conscious person in custody; (ii) that once in that position, monitoring of that person’s state by individuals who are not medically trained can do little or nothing to prevent death; and (iii) that therefore what is essential is that medical attention be sought.

56 It is implicit in the Board’s approach to Dr. Jerreat’s evidence that it appears to have considered the rousing as a means of preventing death. That seems to me to be the wrong approach. The 30-minute checking and rousing targets not the prevention of death but rather the ascertainment of whether unconsciousness or semi-consciousness has set in which in turn indicates that such an individual should not be held in custody but should receive urgent medical attention.

57 Despite my extensive criticism of the Board’s report and findings, one cannot ignore that the case presented for the RGP suffered from significant flaws. The presenter for the RGP in his opening address in essence asserted that the RGP’s policy on rousing was to be found in the Manual and the training courses undertaken by the officers consequent upon the 2002 Orders. The 2002 Orders provided for the implementation of the procedures for a trial period of three months which was thereafter not formally extended. That uncertainty was compounded by the evidence of Insp. Golt and Chief Insp. Smith whose evidence served to highlight the contradiction between various force orders, standing orders and, notwithstanding their rank, their own confusion as to the status of the various documents. Not to ignore either the evidence of Sgt. George Field who, although an RGP witness, testified that he had attended the course but had not been provided with training with regard to the rousing of intoxicated prisoners.

58 As regards the case against Sgt. Ignacio and Const. Edwards (whilst a different conclusion could have been reached premised upon the video evidence), there is also no ignoring that according to Mr. Ford, Mathew was not unconscious on arrival and, that according to Det. Const. Houghton’s statement, Mathew was roused at 13:22 (or 13:27 depending on the camera times). Assuming the former, which would be 32 minutes after Mathew was placed in cells and therefore it could properly be said to amount to compliance with the requirement to rouse every 30 minutes.

59 For the reasons I have given, the Board’s decision cannot be sustained. However, on the basis upon which the case was presented (but not

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necessarily how, with the benefit of hindsight and with a more considered approach, it could have been prosecuted) this case fell into that borderline territory calling for the exercise of the Board's discretion. It was a case in which, respectfully adopting the words of Turner, J. in *R. v. Shippey* (4), the Board should have assessed "the plums" and "the duff" and thereafter determined whether the case as against each individual officer was inherently weak and therefore susceptible to dismissal. It is not of course for this court to undertake that task.

**Want of fairness—Composition, conduct and behaviour of the Board**

60 Given my determination that the Board erred both with regard to the application of the *Galbraith* (3) test and in its approach to the evidence, it is unnecessary to consider all the strands of the arguments advanced in detail. However, certain aspects of the way in which the proceedings were conducted nonetheless require some consideration. Although originally the composition of the Board was one of the grounds upon which the claimant's case was premised, there is no doubt given the clear language of reg. 14(3) of the Police (Discipline) Regulations 1991 that it was in effect abandoned during the course of the hearing.

61 It is said by Mr. Azopardi that the exclusion of the claimant through his representative (his son, Mark Chichon) from attending the disciplinary hearing was in error of law, unreasonable, irrational and contrary to natural justice. It is not in issue and apparent from the transcript that Mark Chichon's exclusion from the proceedings came about after the start of the hearing following an objection by the then counsel to Const. Edwards. It is apparent from reg. 15 of the Police (Discipline) Regulations 1991 that disciplinary proceedings under those Regulations were to be conducted in private subject to the exception created by reg. 18 which allowed for the attendance of a complainant.

62 Mr. Azopardi argues that immediately following Mathew's death the then Commissioner of Police brought over an investigating team from the Metropolitan Police and the complaint board was constituted as if the complaint had arisen from a report by the Police Complaints Board. It is further said that in those circumstances it became unnecessary for Mr. Chichon to lodge a formal complaint but that *de facto* he and his family were complainants and therefore that reg. 18 which provided for the attendance of complainants at hearings should have been read expansively. Mr. Azopardi also intertwined that factual argument with submissions premised on the protection of the right to life contained in s.2 of the Gibraltar Constitution, submitting that the Regulations should have been read in a manner which was consistent with s.2 and allowed the family access to the proceedings to ensure transparency of process. Mr. Azopardi further suggested that when considering whether or not to allow Mr. Mark

Chichon to attend the proceedings, the Board should have taken account of the Police Act 2006, notwithstanding it had not come into effect.

63 Although one can sympathize with the family, the Board was a creature of statute and, properly in this context, did not depart from its statutory obligation. The objection having been raised, it was not open to it to do anything other than exclude Mr. Mark Chichon. Moreover, it cannot be said that there was any residual unfairness in the exclusion. According to Mr. Mark Chichon's witness statement prior to the hearing, he was informed by the Deputy Commissioner that he would be able to attend the disciplinary proceedings provided that there was no objection. At that stage, it was of course open to the family to have sought legal advice, lodged a formal complaint and thereby have ensured the right to attend. There is also, in my view, little merit in the right to life/access to proceedings argument. The duty to undertake an effective investigation into the death was met by the inquest whereas the proceedings before the Board were disciplinary in nature, with the officers, as opposed to the events leading to Mathew's death, of necessity being the focal point.

64 It is also said for the claimant that the transcript evidences a want of fairness and natural justice in the process and that the fair-minded and informed observer would conclude that there was a real possibility of bias. In support of this contention, Mr. Azopardi relies upon various exchanges to be found in the transcript of the proceedings. At a relatively early stage of the proceedings, there is an exchange between Mr. Neish and the chairperson on the following terms:

*Mr. Neish:* I anticipate that we may not need to hear the evidence of the officers . . . and I will be making submissions at some stage . . . in fact, I think we've already heard enough so . . . for this matter to have to go.

*Chairperson:* I agree."

65 Later, the chairperson also said:

"Well, I must say that yesterday when Sergeant Field, not . . . Sergeant Field's brother was giving his statement, I was amazed at the amount of work that a sergeant in charge had to do. And then it was explained to me that since we . . . not this particular incident, but an incident before, the sergeant in charge has in fact less to do now because he is in his office, but when I saw what we've seen, I said well how could he have done any more. Because if he is trying to record what's happening and all the events, I was looking at this and it says, Cell No. 1—Chichon, Cell No. 2—Fleming, Cell No. 3—John . . . Cell No. 4—Bonavia. I mean if . . . you're going to have to deal with all these people, it is sort of in a way you say well you know you can't give everybody complete attention all the time . . ."

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66 On one view, these passages can be relied upon in support of the proposition that the chairperson had pre-judged the submission of no case to answer. Although it may have been desirable for the chairperson to have been more circumspect with her comments, of themselves, they are in my view insufficient to establish bias or procedural unfairness. There is, however, a passage in which the chairperson reacted to the evidence of Dr. Salem, the RGP's forensic medical examiner, which also requires some consideration. The exchange is as follows:

*Dr. Salem:* No, I mean . . . the word unconscious means or the definition of unconsciousness means no response to painful stimuli, not even verbal stimuli, no response to painful stimuli . . . at all. That is a definition of coma or unconsciousness but to my mind I do not think because I was told later on that the word or description of Mathew Chichon's state at that time was that he, there was a word of unconscious I do not believe or I do not think at all that who ever wrote this word actually meant that he was not responding to painful stimuli or any sort of stimuli at all. I do not think, I think it was a word that was wrongly used that is my understanding because obviously I believe that if it was anybody's understanding that unconscious means no response to painful stimuli, I think they would have called me as a doctor as they usually do even with any suspicion about any problem whatsoever regarding a detained person. I do not think they would have hesitated to contact me at all so I think that the word unconscious was wrongly applied or written in the notes at the time.

*Chairperson:* Dr. Salem, I am overjoyed to hear you say this. I would like you to give me a word whereby you could describe that condition."

67 The admission by the chairperson to being pleased by evidence which was exculpatory of the officers palpably raises the real possibility that she unfairly regarded with favour the case of the interested parties. Mr. Azopardi also relies upon various instances which suggest a lack of seriousness by members of the Board. An unfortunate example is to be found in various comments by members of the Board in connection with what were understood to be snoring or laboured breathing by Mathew before his death.

68 Whilst accepting that it is difficult to judge these matters from the perspective of a transcript and that it is not unusual for there to be brief moments of levity in proceedings, however serious the issues and consequences, there are instances in which the conduct of the proceedings fell below an acceptable standard. Although I do not question the integrity of the Board, the procedural impropriety leads me to the conclusion that objectively justice was not seen to be done. In the circumstances, also for these reasons, the decision of the Board cannot be sustained.

**Remedy**

69 Given that the claimant has succeeded in establishing that the Board's decision was unlawful, it is trite law that there is a presumption in favour of the grant of relief. It is, however, a discretionary relief and in exercising that discretion the court can, *inter alia*, look at any delay in bringing the action; at the claimant's "sufficient interest" in the matter; and whether substantial prejudice or hardship would be suffered by the claimant or the interested parties were relief to be granted or withheld.

70 As regards delay in bringing the claim, I dealt with the matter at the permission stage. Whilst it falls to be considered again in the context of the remedy, it is useful to set out what I said on September 26th, 2007:

"The somewhat more difficult issue which arises is whether an extension of time ought to be granted. The claim was filed almost four months after the decision of the Board was made known. It is said for the claimant that the delay can be attributed to him not having legal representation, the solicitors who acted for the claimant in the civil action being unable to act for him for the purposes of the disciplinary proceedings or this claim, given that they act for the second interested party. That of itself might be of limited assistance if correct that the claimant was aware of this since the time of the inquest.

However, it is fair to say that it would appear that the various investigations touching upon the death of Mathew Chichon have been plagued with delay. The inquest was not concluded until December 12th, 2005 (that is over two years from the death), whilst the disciplinary proceedings concluded in late February of this year (that is some 3½ years after the death). Moreover, this court must also accept an element of responsibility in that although the claim was filed on the June 15th, this application was placed before me in September, when rightly the matter ought to have been considered sooner.

I do not ignore the fact that the interested parties have had the disciplinary proceedings hanging over them for a very long time and whilst I sympathize with the distress which the potential re-opening of the case could have on them, it is on balance appropriate to grant the extension of time particularly because in my view the present claim raises issues which are of general public importance."

71 For the purposes of the exercise of my discretion, I remain of the view that given the dilatory manner in which the various proceedings have evolved, not least this judicial review, the claimant's delay in issuing proceedings is at most but a venial failing and one which cannot be relied upon to support the refusal of a remedy.

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72 As regards sufficiency of interest, the Northern Ireland Court of Appeal case of *In re McBride (No. 2)* (2) provides some assistance. That was an action brought by the mother of the victim of a fatal shooting by two soldiers in Northern Ireland. The soldiers were convicted of murder and sentenced to life imprisonment. The applicant sought to challenge a decision by the Army Board not to discharge the two soldiers from the army. Carswell, L.C.J. (as he then was), quoting from an earlier decision of his in *In re D* (1) distilling propositions from case law, had this to say ([2003] N.I. 319, at para. 26):

“(a) Standing is a relative concept, to be deployed according to the potency of the public interest content of the case.

(b) Accordingly, the greater the amount of public importance that is involved in the issue brought before the court, the more ready it may be to hold that the applicant has the necessary standing.

(c) The modern cases show that the focus of the courts is more upon the existence of a default or abuse on the part of a public authority than the involvement of a personal right or interest on the part of the applicant.

(d) The absence of another responsible challenger is frequently a significant factor, so that a matter of public interest or concern is not left unexamined.”

73 Thereafter (*ibid.*, at para. 27), after highlighting as a significant point that if Mrs. McBride could not challenge the decision of the Army Board it was difficult to see who could, he concluded “not without hesitation” that the appellant had sufficient standing to pursue her application. In the present case, the question of standing arises not in the context of an entitlement to pursue the application but rather in the context of whether the claimant has sufficient interest to maintain his claim for the remedy he seeks, namely an order quashing the Board’s decision and remitting the matter for re-hearing. There is also a material difference with *McBride* in that the process being challenged in this action was adversarial in nature and it was always open to the Commissioner of the RGP, who brought the case against the officers, to have challenged the decision of the Board.

74 To make a quashing order and remittal would undoubtedly provide the claimant with the moral vindication he seeks. He would, however, derive no practical benefit. Even the moral vindication could in time turn out to be of limited value given the uncertainty surrounding certain facets of the RGP’s case. The prejudice which would arise in refusing the remedies sought and instead granting declaratory relief is the wider and undoubtedly significant public interest element in police officers being subject to proper disciplinary process—particularly when the facts leading to that process involved a death in custody.

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75 Public interest needs to be balanced against the prejudice which would be suffered by the officers if there were to be a re-hearing. It cannot be ignored that the officers would be put to substantial hardship if this court were to order the quashing of the Board's decision and a remittal. Mathew's death took place almost 6 years ago and it was only some 3½ years later that the officers were cleared by the Board of serious professional misconduct. The deficiencies in the way in which the Board dealt with the matter cannot be ignored but those failings were not materially contributed to by the officers.

76 Similarly, the officers are not to blame for the deficiencies in the case as presented by the RGP. To order a re-hearing now would expose the officers to double jeopardy and possibly afford the RGP the advantage of correcting their earlier approach. That would in my view be unfair to the officers. Moreover, by the time this matter was heard, Sgt. Field had retired and, although I have not been addressed in this regard, it strikes me that it could well prove procedurally difficult to bring fresh proceedings against him. That could well add to a sense of injustice by the other officers.

77 In the circumstances, the appropriate remedy in this case is a declaration recording that the Board erred. I shall hear counsel as to the precise form which the declaration should take consequent upon this judgment and as to costs.

*Order accordingly.*