[2010–12 Gib LR 71]

R. (Application of FRANCIS and FIVE OTHERS) v. H.M. CORONER

COURT OF APPEAL (Aldous, Parker and Tuckey, JJ.A.): September 15th, 2010

Coroners—inquest—coroner's summing-up—unlawful killing—sufficient to describe gross negligence to jury as having high degree of fault—not necessary to describe conduct required as "reckless," "culpable," "wicked"

Coroners—inquest—judicial review—no detailed analysis of inquest procedure, evidence, summing-up necessary—main issue is real risk of injustice/perceived injustice—to consider whether verdict reflects thrust of evidence and not to be set aside if misdirection would not have affected outcome

Coroners—unlawful killing—aggregation of lesser acts—aggregation of lesser negligent acts might support conclusion of grossly negligent conduct if connected or continuing acts but not if acts obviously not connected

The appellants sought a judicial review by the Supreme Court of an inquest jury's verdict of unlawful killing.

The appellants had been nurses at the King George V Hospital, where they had been on night duty in the long-stay and acute wards. Mr. Celecia was at the time of his death a 68-year-old long-stay patient at the hospital who suffered from Alzheimer's. The hospital had known him to be a fire-risk to himself and the appellants because he smoked and, in his confusion, would light objects other than cigarettes. On the day in question, Mr. Celecia was in a restraint chair in the television room at the start of the night shift. He was served tea between 9.00 and 9.30 p.m., for which he was removed from the restraint chair. One of the appellants put him back into the chair, having frisked him, but did not perform a full body search or check the chair for objects. Between 9.30 p.m. and 12.30 a.m., a nurse was in the room with Mr. Celecia. Thereafter, he was left alone by the long-stay staff, who were in the kitchen of the ward. One of the acute ward nurses briefly looked into the room at about 1.10 a.m., but no one was again present with Mr. Celecia until a loud bang was heard at about 1.45 to 2.00 a.m., whereupon four of the appellants discovered Mr. Celecia engulfed in flames. The fire extinguisher failed to work because it

was empty and the fire blanket disintegrated. The appellants attempted to put the fire out using a mop bucket, but Mr. Celecia died from shock caused by burning.

The Coroner left open to the inquest jury the verdict of unlawful killing, which was their final verdict. The appellants sought judicial review of that verdict in the Supreme Court (Dudley, C.J.), which was refused.

On appeal, the appellants submitted that (a) no reasonable jury could, properly directed, have entered a verdict of unlawful killing on the evidence before it (taken at its highest) and the Coroner should therefore have withdrawn the verdict of unlawful killing from the jury; (b) the jury's verdict had been perverse on the evidence before it; (c) the Supreme Court had erred in concluding that a jury could aggregate separate acts and omissions of an individual to establish a grossly negligent course of conduct; (d) the Coroner's summing-up had failed to explain gross negligence as "reckless," "culpable," or "wicked" conduct; (e) the Coroner had failed to identify for the jury the acts and omissions capable of amounting to gross negligence; and (f) the Coroner had misdirected the jury as to the standard of proof by referring to "beyond reasonable doubt" without explaining to the jurors that they must be sure.

The respondent submitted in reply that (a) there had been sufficient evidence for the verdict of unlawful killing to have been left to the jury; (b) the jury's verdict could not therefore have been perverse; (c) whatever the conclusion of the Supreme Court, the Coroner had not directed that the jury could aggregate separate acts and omissions of an individual to establish a grossly negligent course of conduct, and the matter therefore did not fall to be determined in the present proceedings; (d) the Coroner correctly described gross negligence as a high degree of negligence and was not required to refer to "reckless," "culpable," or "wicked" conduct; (e) identifying the acts and omissions capable of amounting to gross negligence was a matter for the jury; and (f) reference to "beyond reasonable doubt" was sufficient to explain to the jury the required standard of proof.

Held, dismissing the appeal:

(1) The court set out the principles governing review of an inquest. First, the court would not embark on an overly detailed analysis of the procedure, evidence, or summing-up. The enquiry was about whether there was a real risk of real, or perceived, injustice. Secondly, the *Galbraith* test should be adopted when determining which verdicts realistically reflected the thrust of the evidence and could therefore be safely left to the jury. Thirdly, if there had been a misdirection that would not have affected the outcome, then the inquest should not be set aside (para. 4).

(2) Applying those principles, the Supreme Court had not erred in dismissing the appellants' claim for judicial review. The Coroner had properly left to the jury the verdict of unlawful killing. The standard of evidence, including the inadequate search and inadequate supervision, was

capable of supporting the conclusion of gross negligence and a reasonable jury could, properly directed, have entered a verdict of unlawful killing on the evidence before it taken at its highest. Moreover, as the jury had been entitled to enter the verdict of unlawful killing on the evidence before it, its verdict had not been perverse (paras. 21–22).

(3) Further, the Coroner had properly directed the jury as to the conduct capable of establishing gross negligence. The issue of whether an individual act of gross negligence was required, or whether a jury could, as the Supreme Court had concluded, aggregate separate acts and omissions of an individual, to conclude that there had been a course of grossly negligent conduct, did not fall to be determined in the present proceedings because the Coroner had directed the jury not to aggregate lesser acts in finding gross negligence. It might be that the approach taken by the Supreme Court would be appropriate in cases of connected or continuing acts or omissions, but not if they were obviously not connected (paras. 8–11).

(4) The Coroner's summing-up had been correct in stating that gross negligence required the degree of negligence to be high. It had not been necessary to further describe the necessary conduct as "reckless," "culpable," or "wicked." Moreover, he had correctly left to the jury the task of identifying the acts and omissions capable of amounting to gross negligence (para. 23–24).

(5) The Coroner had correctly identified the standard of proof as "beyond reasonable doubt," and although it would have been preferable to explain to the jury that they were required to be sure, that omission did not amount to a misdirection (para. 25).

Cases cited:

(1) *R.* v. *Adomako*, [1995] 1 A.C. 171; [1994] 3 W.L.R. 288; [1994] 3 All E.R. 79, followed.

(2) *R.* v. *Galbraith*, [1981] 1 W.L.R. 1039; [1981] 2 All E.R. 1060, followed.

(3) *R.* v. *Inner S. London Coroner*, *ex p. Douglas-Williams*, [1999] 1 All E.R. 344, followed.

E.C. Ellul and *C. Ramagge* for the appellants;
E. Phillips and *M. Zammit* for the respondent;
C.M. Rocca for the family of Mr. Celecia;
G.C. Stagnetto for the Gibraltar Health Authority.

1 **TUCKEY, J.A.:** This is an appeal by the claimants from a judgment of the Chief Justice dismissing their claim for judicial review to quash the verdict of unlawful killing returned by the jury at an inquest into the death of Michael Celecia ("the deceased") held before the Coroner for Gibraltar between May 14th and 31st, 2007.

2 At the time of his death, the 68-year-old deceased was suffering from advanced dementia and was an in-patient in the long-stay ward at the King George V mental hospital. He died of shock caused by burning whilst sitting in a restraint chair in the television room off the ward in the early hours of the morning of December 3rd, 2004.

3 The six claimants were the nursing staff on duty that night in the long-stay ward and the acute ward, which is situated on the floor above the long-stay ward. Their complaints in these proceedings, supported by the Health Authority, which appears as an interested party, are that the Coroner should not have left the verdict of unlawful killing to the jury and that he misdirected them, notably as to the conduct which they could consider in determining whether there had been gross negligence so as to establish this type of involuntary manslaughter, and therefore the basis for an inquest verdict of unlawful killing. Although not spelt out clearly in the notice of appeal, the claimants further contend that the jury's verdict was perverse. The Chief Justice rejected these complaints and the claimants say that he was wrong to do so. The deceased's family, who also appear as an interested party through his widow, support the verdict.

4 At the outset, it is important to remind oneself of the principles which apply when a court is considering a claim to quash an inquest verdict. These principles are not in dispute. The Chief Justice enumerated them as follows by reference to the judgment of Lord Woolf, M.R. in *R.* v. *Inner S. London Coroner*, *ex p. Douglas-Williams* (3):

> "(a) When reviewing the manner in which the Coroner discharged his functions, the court is not to embark upon an overly detailed consideration of the procedure, evidence, or the summing-up, but rather is to enquire as to whether there is a real risk that justice has not been done or seen to be done.
>
> (b) The Coroner, in determining whether to leave a verdict to the jury, is to adopt the *Galbraith* approach. But he need not leave all verdicts but may limit himself to leaving 'those verdicts which realistically reflect the thrust of the evidence as a whole.'
>
> (c) If a misdirection would not have affected the outcome, then the inquest should not be set aside."

5 The reference to the *Galbraith* approach is, of course, to *R.* v. *Galbraith* (2), which requires the judge in a criminal trial to withdraw a charge from the jury if he or she concludes that no reasonable jury properly directed could bring in a verdict of guilty on the evidence put before it, taken at its highest.

6 Before considering the Coroner's summing-up of the facts, it is convenient to set out the ingredients of gross negligence (as opposed to unlawful act) manslaughter, about which again there is no dispute on this

appeal. They were stated by Lord Mackay of Clashfern, L.C. in *R.* v. *Adomako* (1) as follows ([1995] 1 A.C. at 187):

> ". . . [I]n my opinion the ordinary principles of the law of negligence apply to ascertain whether or not the defendant has been in breach of a duty of care towards the victim who has died. If such breach of duty is established the next question is whether that breach of duty has caused the death of the victim. If so, the jury must go on to consider whether that breach of duty should be characterised as gross negligence and therefore as a crime. This will depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred. The jury will have to consider whether the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him, involving as it must have done a risk of death to the patient, was such that it should be judged criminal.
>
> It is true that to a certain extent this involves an element of circularity, but in this branch of the law I do not believe that it is fatal to its being correct as a test of how far conduct must depart from the accepted standards to be characterised as criminal. This is necessarily a question of degree and an attempt to specify that degree more closely is I think likely to achieve only a spurious precision. The essence of the matter which is supremely a jury question is whether having regard to the risk of death involved, the conduct of the defendant was so bad in all the circumstances as to amount in their judgment to a criminal act or omission."

7 It goes without saying that the offence must be proved beyond reasonable doubt, and so an inquest jury must be directed that they must apply this standard of proof before they can return a verdict of unlawful killing.

8 My quotation from *Adomako* (1) enables me to identify one of the issues of law said to be raised by this appeal. It is common ground that the grossly negligent act or omissions alleged must be attributed to the individual defendant alone or acting jointly with others. In other words, it is not possible to aggregate the conduct of one individual with the separate acts of another. What is in issue, however, is whether it is permissible to aggregate the separate acts or omissions of an individual and consider whether his or her conduct as a whole amounts to gross negligence or whether each act or omission must be evaluated separately.

9 Interesting though this point may be, it cannot affect the outcome of this appeal because the Coroner directed the jury as follows:

> "I should add that in order to return a verdict of unlawful killing, the grossly negligent omission(s) must be attributed to a specific individual or specifically to individuals. That is to say in order to return this verdict one (or more) individuals must each separately and as an individual be responsible for a grossly neglectful omission. You cannot add a number of small neglectful acts together to create one act of gross negligence, neither can you add up a number of neglectful acts by different people."

10 The Chief Justice concluded that this summing-up was too favourable to the appellant. He said:

> "I am of the view that when considering a verdict of unlawful killing by virtue of gross negligence manslaughter, a jury is entitled to consider a course of conduct by an individual or individuals acting jointly and it would be wholly artificial to require the jury to focus exclusively on the individual acts constituting that conduct and consider these in isolation, requiring one of these acts of itself to constitute the gross negligence."

11 The claimants argue that the Chief Justice was wrong, but it is unnecessary for us to decide this point in this case because the Coroner's direction was in accordance with the claimants' contention as to what the law is. All I need to say about what the Chief Justice said is that it may hold good in a case of connected and continuing acts or omissions, but it may not where the acts or omissions are obviously not connected. However, this distinction may not in practice be important, given the undoubted need to show that the acts or omissions in question have caused or contributed to the death. But as this is not an entirely straightforward area of the law and we do not need to decide the point in this case, I do not think we should do so.

12 The Chief Justice considered the *Galbraith* point on the basis that the Coroner's direction was correct and I propose to do so also. So I turn to the facts which are helpfully summarized in the Chief Justice's judgment but were considerably elaborated by reference to the notes of the evidence given at the inquest in the course of argument before us.

13 The deceased had been admitted to the hospital for respite care on October 29th, 2004 with a diagnosis of quite severe Alzheimer's type dementia. There was a good deal of evidence about the difficulties of caring for the deceased but, notably, he was known to be a fire risk because he smoked whenever he had the opportunity and, in his state of confusion, he lit things which were not cigarettes. This risk had been underlined on the evening in question by the staff nurse on the day shift who had noted on the nursing sheet: "Day—Usual self wandering the unit aimlessly. Risk of injury (from burning) high, as he is constantly putting cigarette ends in his mouth and trying to light them. Please observe." This

nurse went off duty at 5.00 p.m. The night shift came on at 8.00 p.m. Three of the claimants were assigned to the acute ward. The other three, including auxiliary nurse Bramble, were assigned to the long-stay ward. Nurse Bramble was the senior nurse on this ward; the other two claimants were nursing assistants. Both wards were fully staffed that night. Those present at the handover to the night shift were made aware of the note on the nursing sheet. Nurse Bramble, however, said that he had not seen it. Through no fault of his own he had arrived late. There was evidence however that one of the nursing assistants informed him that the deceased had lit a wax candle and had to be watched because he was a fire risk.

14 When they came on duty, the night shift found the deceased in a restraint chair in the television room. This was a chair with a lap table secured to it by chains which effectively restrained the patient in the chair. There was no clear hospital policy about the use of restraint chairs, although evidence was given at the inquest which criticized their use, particularly for a patient "who was a fire risk being left alone sedated for any length of time."

15 Between 9.00 and 9.30 p.m., tea was served in the television room. Nurse Bramble removed the table from the restraint chair and allowed the deceased to walk about. He was then put back in the chair and given his tea and medication which would have had a sedative effect, but before putting the deceased back in his chair Nurse Bramble's evidence was that he had frisked him but found nothing. In cross-examination he conceded that if he had conducted a proper body search the deceased's death might have been prevented. He also admitted that he had not checked the chair.

16 Between 9.30 p.m. and 12.30 a.m., at least one of the claimants was in the television room, where the deceased remained in his chair. At about 12.30 a.m. he was left alone. Between 12.30 a.m. and sometime between 1.45 and 2.00 a.m., the three claimants on the long-stay ward were in the kitchen of the ward having something to eat, although they had been interrupted when a patient who had absconded was returned to the hospital and had to be escorted to the acute ward. None of these three claimants checked the deceased after 12.30 a.m., but one of the other nursing assistants returning to the acute ward put her head round the door to the television room at about 1.10 a.m. and saw the deceased, whom she described as calm.

17 Between 1.45 and 2.00 a.m., Nurse Bramble and three of the other claimants were in the kitchen when they heard a loud bang coming from the television room. When they got there they found the deceased engulfed in flames. There was no fire protection system in the television room and the fire extinguisher there did not work because it was empty. The fire blanket disintegrated. The fire was, however, eventually extinguished and a cigarette was found under the deceased's left hand and a

lighter was found on his lap table. Cigarette ends were found around his feet which might have been explained by the fact that they had been in a mop bucket which was thrown over the deceased in an attempt to douse the flames.

18 Considering this short summary of the evidence given by 25 witnesses at the inquest in the light of what was required to be proved before the jury could return a verdict of unlawful killing, I understood the claimants, through their counsel, Mr. Eric Ellul, to concede that they owed a duty of care to the deceased, that there was evidence from which the jury could conclude that one or more of them had been in breach of that duty and that such breach or breaches could have caused or contributed to the deceased's death. These concessions were rightly made in my judgment.

19 The essence, however, of Mr. Ellul's submissions was that there was no evidence to support a conclusion that such negligence as there had been was gross. In other words that it was so bad that the jury could conclude that it amounted to a crime. It followed, he submitted, that the Coroner should not have left a verdict of unlawful killing to the jury, alternatively that the jury's verdict was perverse.

20 In support of these submissions, Mr. Ellul took us through the Coroner's notes of the evidence by reference to different heads under which the claimants might have been open to criticism and submitted that none of the evidence showed gross negligence on the part of any of the individual claimants, although there was ample evidence of systemic failure on the part of the hospital for which the claimants could not be blamed, and against the background of which their conduct had to be judged.

21 I do not think that it is instructive to set out and evaluate these submissions in detail, bearing in mind that it was not for the Coroner but for the jury to decide which acts or omissions they considered to be negligent, and whether such negligence was gross, and that, in a case such as this, the appellate court will not know the reasons for the jury's verdict. Its role of necessity is confined to considering whether the coroner has properly applied the *Galbraith* test (could the evidence taken at its highest justify the verdict?) and whether he properly directed the jury as to the law. Like the Chief Justice, I think there was evidence to justify the verdict. For the reason I have already given, he cannot be criticized for failing to go through the evidence in detail. He did, however, say at para. 29 of his judgment:

> ". . . [T]he Coroner approached the matter . . . by focusing upon distinct individual acts/omissions. From that narrower perspective there are two distinct matters, both attributable to Bramble, which could be considered material. That is, the inadequate search and the failure to ensure adequate supervision of a patient in a restraint chair.

> Each of those considered distinctly is, given the factual matrix, of sufficient gravity to have entitled the Coroner to determine that they potentially amounted to gross negligence and had sufficient causal nexus with the death. Whether either of itself amounted to a grossly negligent act or omission or merely negligent acts or omissions is a question of degree and was therefore properly left for determination by the jury"

I agree.

22 For these reasons, I conclude that Mr. Ellul's submissions based on *Galbraith* (2) fail. Likewise the submission that the jury's verdict was perverse. If there was evidence capable of supporting a verdict of unlawful killing, such a verdict cannot be characterized as perverse.

23 This leads to the criticisms of the Coroner's summing-up, which were developed by Mr. Carl Ramagge on behalf of the claimants. First, he said that the Coroner did not adequately define what was meant by gross negligence and should have used some of the language deployed in the pre-*Adomako* cases to which we were referred, such as "reckless," "culpable," or "wicked," to emphasize the degree of negligence required. The Chief Justice rejected this criticism on the basis that it was over-zealous. I agree. The Coroner followed the passage from *Adomako* (1) which I have already quoted. What he said was:

> "If you are satisfied that there was a duty, and that duty was breached, then you go on to consider whether those breaches amount to gross negligence. That is to say, did those acts or omissions amount to a crime, *i.e.* conduct that would justify a criminal sanction and not just a matter of compensation. The negligence would have to be to a high standard."

This was an adequate, if slightly terse, direction in my judgment.

24 Then it is said that the Coroner should have identified the acts or omissions which were capable of amounting to gross negligence. But that was a matter for the jury, as I have already said.

25 Finally, it is argued that when directing the jury that they had to be satisfied "beyond reasonable doubt" before they could return a verdict of unlawful killing (as he did), the Coroner should have added that what this meant was that they had to be sure. I agree with the Chief Justice that it would have been preferable for the Coroner to have done so, but such an omission cannot possibly have been fatal to the summing-up. The words "beyond reasonable doubt" on their own accurately convey the standard of proof required. Like the other criticisms of the summing-up, if there was any misdirection, I cannot think that it affected the outcome of the inquest. Accordingly, following the principles to which I referred at the beginning of this judgment, this court should not interfere with the jury's verdict.

26 For these reasons, I would dismiss this appeal.

27 Before leaving this case, however, I should like to say that, as well as great sympathy for the family who have lost the deceased in the tragic circumstances which I have described, one must also express sympathy for nursing staff who work in wards of the kind with which this case is concerned, particularly in times of diminishing resources. Through no fault of their own, the patients are often difficult and often, as here, the hospitals in which they work have not had equipment, developed systems, or provided training to the highest standards. Lessons have obviously been learned from this case and I would hope that the family can draw comfort and satisfaction from the fact of the inquest and the jury's verdict which has been upheld by this court and that the authorities will conclude that it would not be in the public interest to invoke the criminal process against any individual.

28 **TUCKEY, J.A.:** I agree and would wish to associate myself in particular with the concluding words of My Lord's judgment.

29 **PARKER, J.A.** concurred with both judgments.

Appeal dismissed.