[2023 Gib LR 300]

R. (OFFICER 1 and OFFICER 2) v. H.M. CORONER

(ROYAL GIBRALTAR POLICE and CHICON as interested parties)

SUPREME COURT (Dudley, C.J.): April 19th, 2023

2023/GSC/018

Coroners—"unlawful killing"—serious and obvious risk of death—failure to direct jury that gross negligence requires "serious and obvious" risk of death—challenge to finding of unlawful killing dismissed because limited misdirection would not have affected outcome of inquest—police officers pursued suspect vessel at sea at high speed in dark, suspect vessel manoeuvred dangerously and collision occurred killing two occupants of suspect vessel—overwhelming evidence of serious and obvious risk of death

The claimants applied for judicial review.

At the relevant time the claimants were Royal Gibraltar Police officers. They had been involved in a collision at sea with another vessel, a rigid hulled inflatable boat ("RHIB"). The RHIB was the type of boat used by drugs importers. The officers, in a RGP interceptor vessel, had pursued the RHIB with the intention of identifying the suspects on board and determining whether the RHIB was carrying illegal cargo. There was a high speed pursuit, at night, during which objects were thrown from the RHIB and the RHIB, which was not displaying any lights, made numerous sharp turns spraying seawater onto the RGP vessel and significantly reducing its visibility. After one sharp turn by the RHIB in front of the RGP vessel, the RGP vessel collided with the RHIB. Two of the four persons on board the RHIB died. The collision occurred in Spanish waters.

The expert who prepared a report for the jury stated *inter alia* that the crew of the RGP vessel placed themselves so close to the RHIB, which was carrying out dangerous manoeuvres, that they placed themselves and the crew of the RHIB in considerable danger. The officers disputed this conclusion and gave evidence that they had kept a safe distance away from the RHIB, that they believed they were in British Gibraltar territorial waters; and that RGP was aware that high speed pursuits routinely occurred, indeed the expectation was that such pursuits would be conducted by RGP marine section officers applying adapted skills acquired during training. The RGP

disagreed, asserting that maritime training instructions expressly stipulated that RGP officers were only to pace a suspect vessel, not to endeavour to immobilize it.

Following an inquest before H.M. Coroner, an inquest jury found that the two deceased persons from the RHIB had been unlawfully killed. The Coroner had left two possible conclusions to the jury: unlawful killing on a gross negligence manslaughter basis and accidental death/death by misadventure.

The officers sought to challenge that conclusion on three grounds:

(1) The direction on the duty of care owed by the officers to those on the RHIB during the pursuit was wrong. The Coroner should have directed the jury that the officers' duty was to "exercise such care as was reasonable in the circumstances."

(2) The direction on breach of duty was wrong. The Coroner should not have directed the jury that the duty was breached if Officer 1 "negligently exposed the occupants of the RHIB to risk of harm." The jury should instead have been directed to consider whether specific acts or omissions breached the duty of care owed to those on the RHIB. As a matter of law there could be exposure to a risk of harm without any breach of the duty owed by the police to suspects in the course of a pursuit.

(3) The direction on the threshold for the foreseeability of death was wrong. The Coroner should have directed the jury to consider whether it was foreseeable that there was a "serious and obvious" risk of death as a result of any breach of duty, which was the third element of the offence of gross negligence manslaughter. The Coroner failed to adequately direct the jury on this third elements of the offence, which also had the consequence of inadequately directing the jury on the issue of the "grossness" of the breach of duty.

The court granted permission to apply for judicial review in respect of the third ground and ordered that the application for permission in respect of the first and second grounds be determined at the substantive hearing.

In relation to ground 1, the officers submitted that (a) the Coroner materially misdirected the jury by limiting the direction in respect of the duty of care to "not to act in such a way as to expose the occupants of the RHIB to harm"; (b) the scope of the duty of care should have been formulated in terms of exercising "such care and skill as [was] reasonable in all the circumstances"; and (c) the effect of the Coroner's direction was to set a threshold too low, with the following consequences: (i) the jury was wrongly required to consider the duty of care by reference to exposure to risk of harm rather than by reference to whether the officers exercised such care and skill as was reasonable in all the circumstances, which circumstances could be consistent with exposing individuals to a significant degree of risk; (ii) the jury could have concluded that the duty not to expose the RHIB's occupants to a risk of harm was breached simply by the fact of the collision, rather than whether the collision had occurred despite the officers' exercising reasonable skill and care; (iii) by failing to require the jury to consider all the circumstances when assessing whether the duty had

been breached, the jury would have focused on the risk of harm rather than taking into consideration all of the other factors which were relevant to the assessment of breach of duty; and (iv) the jury would have assessed the grossness of the breach by reference to the risk of harm, rather than by reference to the officers' exercise of reasonable skill and care.

In relation to ground 2, the officers submitted that (a) the Coroner's direction as regarded breach of duty of care, in which the Coroner posed the question whether the duty of care was breached "because Officer 1 handled [the RGP vessel] in such a way during the chase that he negligently exposed the occupants of the RHIB to risk of harm," was circuitous; (b) the Coroner should instead have directed the jury to consider whether specific acts or omissions amounted to a breach of the duty owed by the officers; (c) the duty of care owed by police officers could in some circumstances be consistent with exposing individuals to a significant degree of risk; and (d) by in effect setting the threshold for the breach of duty too low the jury would have assessed the grossness of the breach from an incorrect starting point.

In relation to ground 3, the officers submitted that although the Coroner correctly focused the jury's attention on the foreseeability of death (rather than anything less) as a consequence of the pursuit and directed the jury to consider whether the risk of death was a reasonably foreseeable consequence of the way the RHIB was handled, he failed also to direct the jury to consider whether they were satisfied that a reasonably prudent person in the position of Officers 1 and 2 would have foreseen that the acts or omissions comprising the breach of duty exposed the deceased to an obvious and serious risk of death.

Held, dismissing the application:

(1) Ground 1 was arguable but it would be dismissed. The evidence before the jury in relation to the engagement, pursuit and collision taking place outside British Gibraltar Territorial Waters was not capable of objective challenge. Nor was there any evidence before the jury that the engagement outside Gibraltar waters came about consequent upon a pursuit from Gibraltar waters into Spanish waters in order to stop or arrest beyond Gibraltar waters. Irrespective of whether or not the officers were proceeding in the honest belief based on reasonable grounds that they were engaging the suspect RHIB in Gibraltar waters, they did so in Spanish waters in which they had neither jurisdiction nor powers of arrest. In the absence of any such jurisdiction or powers of arrest, it followed that the officers could not have been acting in the execution of their duty as RGP officers. Without that authority, in chasing in Spanish waters a vessel suspected of criminal activity the care and skill as was reasonable in all the circumstances was neither more nor less than that of ordinary citizens. Applying the neighbour principle, a sea-going vessel owed a duty of care to other vessels navigating the same seas. The Coroner's direction as regarded the scope of the duty of care owed by the officers to the crew of the suspect RHIB was somewhat stark, but nonetheless accurate and sufficient (paras. 18–24).

(2) The arguability test was also met in respect of ground 2, but that ground would also be dismissed. For the reasons given in respect of ground 1, the court discounted the submissions in so far as they were premised on the duty of care owed by police officers. It was right to say that there was an element of circularity in the way in which the jury were invited to determine whether the duty of care had been breached. The focus ought to have been on specific acts or omissions and could have been canvassed in terms of Officer 1's navigation of the RGP vessel by reference to the speed at which he was travelling, the manoeuvres undertaken and whether these were reasonable in the circumstances. However, given the factual matrix, the Coroner's direction did not amount to a material misdirection. The Coroner's direction was not as focused as it could have been but in essence it posed the right question, namely did Officer 1's navigation of the vessel breach the duty of care owed to the occupants of the RHIB (paras. 27–30).

(3) In relation to ground 3, the Coroner failed to direct the jury fully in relation to the elements that had to be proved for gross negligence manslaughter. He failed to direct them that one of the elements was that at the time of the breach of duty of care there was a "serious and obvious risk of death." He also failed to include the words "serious and obvious" when directing the jury as to foreseeability. However, the deaths of two of the occupants of the RHIB was a consequence of a collision between two very high powered vessels involved in a high speed pursuit, at very close range, in the dark, in which the RHIB was not displaying any lights, the occupants of the RHIB threw objects to impede the RGP vessel and made evasive manoeuvres, crossing the path of the RGP vessel and spraying water onto it thereby reducing visibility. It was self-evident that navigation in this manner created a serious and obvious risk of death and the absence of specific training in high speed pursuits clearly pointed to the fact that they were inherently extremely dangerous. The evidence before the jury was such that no legitimate criticism could be levied against the Coroner for leaving the verdict of unlawful killing to the jury. The issue for determination was that of reasonable foreseeability. The Coroner's failure was therefore limited to his directing the jury to consider whether there was a "risk of death" as opposed to a "serious and obvious risk of death." This was a case in which there was overwhelming evidence of a serious and obvious risk of death and that consequently such risk was reasonably foreseeable at the time of the breach. In all the circumstances, the limited misdirection would not have affected the outcome of the inquest and there was no real risk that justice had not been done or seen to be done. The application for judicial review would be dismissed (paras. 38–43).

Cases cited:

(1) *Broughton* v. *R.*, [2020] EWCA Crim 1093; [2021] 1 W.L.R. 543; [2021] All E.R. 819; [2021] Crim. L.R. 869; [2020] Med. L.R. 477, applied.
(2) *Kuddus* v. *R.*, [2019] EWCA Crim 837, considered.
(3) *Marshall* v. *Osmond*, [1983] Q.B. 1034, considered.

(4) *Misra* v. *R.*, [2004] EWCA Crim 3275; [2005] 1 Cr. App. R. 21, referred to.
(5) *R.* v. *Adomako*, [1995] 1 A.C. 171; [1994] 3 W.L.R. 288; [1994] 3 All E.R. 79, considered.
(6) *R. (Douglas-Williams)* v. *Inner South London Coroner*, [1999] 1 All E.R. 344, referred to.
(7) *R. (Francis)* v. *H.M. Coroner*, 2010–12 Gib LR 71, considered.
(8) *R. (Maughan)* v. *H.M. Senior Coroner for Oxfordshire*, [2020] UKSC 46; [2021] A.C. 454; [2020] 3 W.L.R. 1298; [2021] 3 All E.R. 1; [2021] Med. L.R. 1; [2020] Inquest L.R. 175, referred to.
(9) *Robinson* v. *West Yorks. Police (Chief Const.)*, [2018] UKSC 4; [2018] A.C. 736; [2018] 2 W.L.R. 595; [2018] 2 All E.R. 1041; [2018] PIQR P9, considered.
(10) *Rose* v. *R.*, [2017] EWCA Crim 1168; [2018] Q.B. 328; [2017] 3 W.L.R. 1461, considered.

J. Hodivala, K.C. with *C. Bonfante* (instructed by Hassans) for the claimants;
N. Costa with *J. Warwick* (instructed by Isolas LLP) for the first interested party;
C. Finch (instructed by Verralls LLP) for the second interested party.

1 **DUDLEY, C.J.:** On November 26th, 2021, following an inquest held over nine days, before H.M. Coroner Charles Pitto, touching upon the deaths of the late Mohammed Abdeslam Ahmed and Mustafa Dris Mohammed, the inquest jury found:

(i) that they both died of "multiple injuries";

(ii) as to the time, place and circumstances, at or in which injury was sustained, that "at time of impact 03:38 08 March 2020, outside British Gibraltar, Territorial waters, in Spanish waters. Collision between RGP [Royal Gibraltar Police] vessel, Sir John Chapple and RHIB [rigid-hulled inflatable boat] and over running it"; and

(iii) the conclusion as to the deaths was "unlawful killing."

It is the conclusion that both deceased were unlawfully killed which is challenged in these proceedings by Officers 1 and 2.

2 Immediately upon the filing of the claim I made an anonymity order in respect of the claimants, who at the material time were Royal Gibraltar Police officers on board the *Sir John Chapple*, and whose identity had likewise been anonymized for the purposes of the inquest.

3 The claim is brought on three grounds which are summarized at para. 5 of the claimants' statement of facts and detailed grounds as follows:

"a. The direction on the duty of care owed by the Officers to those on the RHIB during pursuit was wrong. The Coroner should have

directed the jury that the Officers' duty was to 'exercise such care as was reasonable in all the circumstances' ('First Ground');

b. The direction on breach of the duty was wrong. The Coroner should not have directed the jury that the duty was breached if Officer 1 'negligently exposed the occupants of the RHIB to risk of harm.' The jury should instead have been directed to consider whether specific acts or omissions breached the duty of care owed to those on the RHIB. As a matter of law, there can be exposure to a risk of harm without any breach of the duty owed by the police to suspects in the course of a pursuit ('Second Ground');

c. The direction on the threshold for the foreseeability of death was wrong. The Coroner should have directed the jury to consider whether it was foreseeable that there was a 'serious and obvious' risk of death as a result of any breach of duty, which is the third element of the offence of gross negligence manslaughter. The Coroner failed to adequately direct the jury on this third element of the offence, which also had the consequence of inadequately directing the jury on the issue of the 'grossness' of the breach of duty ('Third Ground')."

4 By his acknowledgment of service, the defendant, H.M. Coroner, stated that he did not intend to make a submission in these proceedings, therefore in effect he adopts a neutral stance. Acknowledgments of service and summary grounds of resistance were filed by both interested parties, namely the Royal Gibraltar Police ("the RGP") and Ms. Chicon, the widow of one of the deceased, purportedly representing the families of both deceased.

5 Following a directions hearing, by order dated February 28th, 2022, I granted permission in respect of the third ground and ordered that the application for permission in respect of the first and second grounds be determined at a substantive rolled-up hearing. I further directed that the RGP's amended summary grounds of resistance, and its subsequent response to the claimants' reply to summary grounds of resistance, were all to stand as the interested parties' detailed grounds for contesting the claim.

6 In the statement of facts and detailed grounds attached to the claim form, the following is to be found by way of summary of the facts which is said to be largely derived from an expert report prepared by Richard Miekle ("Mr. Miekle") of Solis Marine Group LLP trading as Solis Marine Consultants. Mr. Miekle gave evidence and read out his report ("Mr. Miekle's report"/"the Solis report") to the jury.

"The drugs trade

10. The drugs trade between Morocco and Gibraltar is well known and well established. RHIBs (Rigid Hulled Inflatable

Boats) are the vessel of choice for these drug importers because they can travel at over 60 knots, which is close to 120km/h.

11. The Royal Gibraltar Police ('RGP') Marine Section faces a high-risk and dynamic working environment at sea in their efforts to counter organised crime and international drug trafficking.

The crew of the Sir John Chapple

12. The Sir John Chapple is an 'interceptor' vessel and is one of six vessels operated by the RGP Marine Section. It is 11.8 metres in length, 3.05 metres wide, has an operational load of 9.27 tonnes and is capable of carrying 24 people and a maximum speed of 55 knots. The Sir John Chapple was not fitted with forward looking infra-red cameras or any form of night-vision.

13. The bow of the Sir John Chapple is fitted with log defenders—a serrated metal strip which prevents floating debris from passing under the hull towards the propellers. It was also fitted with 'push knees'—vertical rubber fenders, which protect the bow of the vessel when pushed onto a berth or another vessel.

14. Officer 1 was a Senior Coxswain and in control of the vessel at all material times. He has been a police officer since 2012 and joined the Marine Section in 2015, becoming a fully qualified coxswain in 2017. He had completed Royal Yachting Association operated STCW 95 ('Standards of Training, Certification and Watchkeeping for Seafarers') courses in sea survival, first aid, navigation and firefighting as well as a week-long course that included radar and VHF radio training (including practical assessment). He had also completed a two-week fast RHIB course, which included high speed navigation and pacing (the manoeuvring alongside of two compliant vessels at speed).

15. Officer 2 joined the RGP in February 2008. He had completed an RYA Powerboat Level 2 qualification, RYA Day Skipper Theory qualification and was trained to STCW 95 standard in sea survival, first aid, navigation and firefighting in 2011. He qualified as a Gibraltar Maritime Administration Boat Master in 2014 and completed an RGP in-house GMA Interceptor RHIB course in 2016. He also held VHF radio and radar operator qualifications.

16. Officer 3 was a police officer in the United Kingdom from 2013 to 2017, and joined the RGP in 2018. He had no marine qualifications.

The crew of the suspect RHIB

17. The RHIB was unregistered and the location of the build is unknown. It appeared to be new. It was 14 metres long and 3.15 metres wide, with a maximum speed of 51.5 knots. It was fitted with four outboard engines producing a combined power of 1,200 horsepower.

18. The crew of this RHIB comprised four men, sat in a jockey formation. Seat 1 was the pilot, Seat 2 operated the radar/plotter unit, with Seats 3 and 4 observing the Sir John Chapple and recommending manoeuvres the RHIB should make.

19. Significant efforts had been made to ensure that no lights were visible from the RHIB, including the dashboard display and indicator lights which had been taped over to conceal them during use.

Events leading to the collision

20. At around 01.38hrs on 8 March, Officers 1, 2 and 3 embarked upon the Sir John Chapple at RGP Marine Base at Gun Wharf Quay to conduct routine patrols.

21. At 02.35hrs, a suspect RHIB headed towards the Spanish port of Puerto de La Atunara from her position 11 nautical miles to the east.

22. A mobile phone call was received on the RGP Marine Section mobile phone from Windmill Hill Signal Station ('WHSS') at an unknown time reporting that there was an unknown vessel without navigation lights heading westwards towards the coast.

23. The Coxswain of the Sir John Chapple, Officer 1, called the Spanish Guardia Civil and informed them of the information they had received. The report was confirmed by the Guardia Civil, upon which Officer 1 confirmed that he would deploy to the East side of Gibraltar.

24. The radar was turned on and the GPS chart-plotter was left off as Officer 1 felt that it reduced his night vision. This meant that the vessel's AIS, which is linked to the chart-plotter was not on.

25. Officer 1 was sat in the conning position (starboard forward) with Officer 2 on the port side forward position and Officer 3 sat in the seat on the starboard side behind Officer 1.

26. As the Sir John Chapple arrived on the Eastern side of Gibraltar, Officer 1 received a mobile phone call from the Guardia Civil, updating the RHIBs movements. The Sir John Chapple was instructed to head to the east of the port and wait.

27. The RHIB, that was by the Atunara port, had the four crew on board who were informed of the presence of the Sir John Chapple by "spotters" ashore and in smaller boats. The RHIB then headed away from the Spanish coast.

28. Officer 1 was instructed to remain in its current location by the Guardia Civil as the RHIB was heading directly for its location. When the RHIB was viewed on the Sir John Chapple's radar as being within 0.25nm, Officer 1 turned on his blue beacon lights to inform the RHIB of their presence. Officer 1 stated that the RHIB then passed between 5m–10m in front of the bow of the Sir John Chapple, which then followed in a high-speed pursuit.

29. Officer 1 gave evidence that the intention was to identify the suspects and determine whether the RHIB was carrying illegal cargo. The RHIB was not displaying any lights (navigational or otherwise). Officer 1 gauged that the RHIB was heading towards Morocco. Officer 1 approached the RHIB's port side and Officer 2 shone his Dragon torch on the vessel.

30. The RHIB was illuminated by the blue beacon and the Dragon torches held by Officers 2 and 3. As is a common tactic used by smugglers, objects were thrown by the occupants of the RHIB. A surviving member of the RHIB denied that the Sir John Chapple used its blue beacon lights or navigation lights.

31. During the pursuit, the RHIB made numerous sharp turns, spraying seawater onto the Sir John Chapple and thereby significantly reducing visibility. This forced it to slow down, which Officer 1 did as necessary. The RHIB continued to produce spray from its outboard engines.

32. Officer 1 stated that he saw the RHIB make a sharp turn to port, whereupon he attempted to turn to starboard to avoid the RHIB by slowing down and turning away. Officer 2 stated that the RHIB had passed very close to the Sir John Chapple and that spray had reduced visibility from the windows.

33. Officer 2 then stated that he felt an extremely large and sudden impact that caused the Sir John Chapple to stop abruptly. Their vessel immediately began to tilt to starboard, the side window slammed into the water and water began flooding in. Officers 1 and 2 stated that they feared for their lives.

34. It appears that the Sir John Chapple collided with the rear left-hand side and partially went over the RHIB. The Sir John Chapple then righted and manoeuvred alongside the RHIB. Officer 1 and Officer 2 were in shock but boarded the RHIB. One of the crew was apparently dead and a second seriously injured.

35. The Sir John Chapple then informed WHSS [Windmill Hill Signal Station] of the fatality and that they were heading back to RGP Marine Base. Officer 1 requested an ambulance crew to stand by. They towed the RHIB back, although this took longer than expected as one of its engines had failed following the collision.

36. The Sir John Chapple was met by Her Majesty's Customs vessel HMS Seeker, which took the RHIB's crew aboard. As the HMC vessel approached, Officer 1 (supported by Officer 2) recalled one of the RHIB crewmen stating in Spanish:

> 'Officer it was our fault as our engines stopped, we didn't give you enough time to stop, please help my uncle, I know you guys didn't want to kill anyone.'

37. HMC Officer 5 aboard HMS Seeker recalls one of the RHIB crewmen stating in Spanish:

> 'This has been an accident we have just changed crew is [*sic*] Alcaidesa and no one has informed me the engines were failing, consequently they have rammed into us.'

38. HMC Officer 6 (supported by HMC Officer 7) recalls another of the RHIB crewmen saying in Spanish:

> 'I am El Nordin and I work for someone big in Spain, this has happened in Spain and I have recorded everything, I've sent it to my boss. We have only been aboard 10 minutes and we have had engine problems.'

The other crew did not say anything.

39. Mr. Driss, one of the survivors from the RHIB, was required to give evidence by the Coroner but did not attend the inquest (he was apparently subject to criminal proceedings in Spain and was unable to leave that jurisdiction). Mr. Driss' statement was read to the jury. He confirmed that they were informed that one of the engines was faulty when they took over the crewing of the RHIB and stated that the RHIB had come to a complete stop as the engines had broken down. He alleged that the Sir John Chapple deliberately rammed into the RHIB,

having seen that it was disabled. Mechanical examination did not subsequently find any fault with the RHIB's engines.

40. At 04.47hrs the Sir John Chapple began transmitting an AIS signal, which was recorded by the Gibraltar Vessel Traffic System (VTS). At 05.20hrs the Sir John Chapple berthed at RGP Marine Base with the assistance of a Gibraltar Defence Police RHIB.

41. Shortly thereafter, Officers 1, 2 and 3 were informed that a Post Incident Procedure had been initiated by the police and on the morning of 8 March the Officers provided their initial statements. Further statements were provided by them on 16 March."

7 The statement of facts then deals with the collision itself in respect of which reference is made to Mr. Miekle's expert opinion evidence at para. 3.11.3 of his report in which he states that:

"By not using the available navigation equipment while navigating at night with no position monitoring, other than by eye, the crew of SIR JOHN CHAPPLE showed that a poor standard of navigation was being practiced at the material time."

Although he went on to conclude at his para. 3.11.5:

"As collision avoidance was being carried out by sight, and with the two vessels at very close range, it is my opinion that the electronic equipment, in particular the radar, would not have assisted the crew of SIR JOHN CHAPPLE in collision avoidance."

The statement of facts then summarizes Mr. Miekle's para. 3.8.3 *et seq.* of his report on the following terms:

"that the chase occurred at high speed, with the RHIB making sharp turns to deter the RGP vessel. When rapid turns were made, the RGP Officers responded by trimming the engines to make the vessel more manoeuvrable and able to respond to the fast turns of the RHIB they were pursuing."

And continues by quoting his paras. 3.8.5 to 3.8.7 as follows:

"3.8.5 quick turns of the Suspect RHIB produced spray which significantly reduced the visibility of Officer One and Officer Two; a common tactic known by RGP Officers to be used by drug smugglers. The reduced visibility in the cabin considerably increased the risk of collision with the evasive SUSPECT RHIB. Only by slowing down substantially and increasing the distance from SUSPECT RHIB would the risk of collision have been appreciably reduced.

3.8.6 When SUSPECT RHIB turned immediately in front of SIR JOHN CHAPPLE the spray, as reported by Officer One and Officer Two reduced visibility to zero. None of the RGP Officers could recall witnessing the collision occur.

3.8.7 Although Officer One stated that he took avoiding action by stopping and turning to starboard, his actions were insufficient to avoid the collision. The speed of the collision led to SIR JOHN CHAPPLE passing over the top of SUSPECT RHIB and, once clear, landing on their starboard side at a large angle which led to the water ingress into the cabin."

Thereafter, in relation to the risks involved, at his para. 3.12.2 Mr. Miekle stated:

> "the crew of SIR JOHN CHAPPLE placed themselves so close to the SUSPECT RHIB, which was carrying out dangerous manoeuvres and risked the safety of the crews of both vessels, as to place themselves and the crew of SUSPECT RHIB in considerable danger."

8 The position as set out in the claimants' statement of facts is that this conclusion was plainly disputed by Officers 1, 2 and 3 who all gave evidence that they were a safe distance away from the RHIB. The evidence of Officers 1 and 2 is thereafter set out, including by reference to statements made by them as part of the investigation and the transcript of the evidence at the inquest, which is then summarized as follows:

"Officer 1's evidence

. . .

52. He was questioned about his knowledge of the territorial limits of [British Gibraltar Territorial Waters] BGTW, the AIS and whether in fact he had intended to ram the RHIB. Officer 1 confirmed the following:

a. That his understanding was that the AIS turned on with the boat;

b. That he believed the AIS was on that night;

c. That the AIS would not have made any difference to the chase and collision had it in fact been on;

d. That the Guarda [*sic*] Civil had not complained about the Sir John Chapple being in Spanish waters;

e. That his attention was focused on the radar when he got the call from the Guarda [sic] Civil;

f. That he believed he was in BGTW;

g. That he has never previously been involved in a collision following a pursuit;

h. That he kept a safe distance from the RHIB;

i. That just before the collision the RHIB was on his starboard side and then made a sharp turn to port, taking it across his bow and the path of his boat;

j. This resulted in a wall of water spraying up, which blocked his vision;

k. That he is unable to stop the vessel, so went into neutral and turned the boat to starboard because he knew that nothing would be there.

Officer 2's evidence

. . .

55. He confirmed the following matters in his evidence:

a. The AIS is always on;

b. He believed they were in BGTW and not Spanish waters;

c. That they pursued the RHIB from a distance of 20m–30m, which he believed to be a safe distance;

d. The RHIB started doing evasive manoeuvres, crossing their path;

e. That the RHIB caused water to splash up onto their windscreen 3 or 4 times;

f. Immediately prior to the collision the RHIB sprayed water onto the windscreen and then he felt a sudden impact;

g. He would have told Officer 1 to stop if he had discerned that there was any intent to ram the RHIB. There was not;

h. That if he had felt unsafe at any point he would have pulled the 'kill cord' which cuts off the engines;

i. That they are permitted by the rules of engagement to conduct high speed pursuits."

9 Albeit as part of the detailed statement of grounds, rather than the statement of facts, for the claimants at para. 89 it is said that:

"[t]he evidence was that RGP were aware that high speed pursuits routinely occurred. Indeed, the expectation was that such pursuits would be conducted by RGP Marine Section officers applying adapted skills they had acquired during training."

10 This is advanced in support of the proposition that in those circumstances, foreseeability of a "serious and obvious" risk of death cannot be established merely by virtue of the *Sir John Chapple* pursuing the RHIB.

11 That assertion of fact at para. 89 is one which is challenged by the RGP. At para. 33 of their response to the claimants' reply to summary grounds of resistance they state:

> "33. The RGP submits that it disputes the contents of paragraph 89 as it contains a material and significant omission. I draw this Honourable Court to paragraphs 2.5.6 to 2.5.10 of the [Solis report]. The Solis Report defines pacing at paragraph 2.1.1 as the manoeuvring alongside of two patrol vessels at speed. It is paramount to note that the RGP does not have any marine training instructions to immobilise a vessel. The instructions expressly stipulate that RGP officers are only to 'pace' the vessel, and not to endeavour to immobilise a suspect vessel, in the hopes that the suspect vessel breaks down, stops voluntarily, runs out of petrol, or jettisons its cargo, among other eventualities. The inquest jury heard consistent evidence from the officers in this respect. The Solis Report notes as follows:
>
> > 2.5.6. One of the lesson plans for the two-week course included an introduction to pacing in week one and pacing drills in daylight and at night, as well as night pacing assessment during the second week. Pacing, where two power boats manoeuvre alongside each other at speeds of up to 35 Knots.
> >
> > 2.5.7. The lesson plan for the Pacing Manoeuvres included Pacing in parallel and pacing alongside. The objective of the pacing manoeuvre training was for Students to demonstrate a safe handling of vessels when performing manoeuvres in the following areas:
> >
> > i. When performing the Approach
> >
> > ii. Parallel pacing of target vessel
> >
> > iii. Coming alongside target vessel
> >
> > iv. Departing target vessel.
> >
> > 2.5.8. The five RGP Marine Section instructors were asked for their views on whether training in the pursuit of suspect vessels was provided. In summary, it was their view that while pacing training at high speeds was carried out, that no training was specifically provided for the pursuit and apprehension of suspect vessels.

> It was the general view of the RGP marine section trainers that aspects of other modules in the training, such as pacing and safe manoeuvring, 'are then applied in relation to safely pursuing vessels.'
>
> 2.5.9. No specific training is provided to RGP Marine Section Coxswains in high-speed pursuits.
>
> 2.5.10 As there is no established safe method of stopping a suspect vessel at sea, and this is prohibited by the instructions provided, no training is provided for this manoeuvre."

12 The Coroner left two possible conclusions to the jury, namely "unlawful killing" on a gross negligence manslaughter basis and accidental death/death by misadventure. Following his summing up and the retirement of the jury Mr. Bonfante (who then and now appeared for Officers 1 and 2) expressed certain concerns in relation to the directions of law. The Coroner took account of those concerns, he again addressed the jury and gave the following directions both orally and in writing. It is not in issue that it is those latter directions which fall to be considered. The Coroner said:

> "The first point for your consideration is that of unlawful killing. You must consider this verdict first, and then if you are not satisfied you can return such a verdict, do you go on to consider the other verdict I'm giving you.
>
> In order to return a verdict of unlawful killing, you must be satisfied on the balance of probabilities of each of the following elements:
>
> - That those on the RHIB were owed a duty of care by the crew of [the Sir John Chapple], a duty not to act in such a way as to expose the occupants of the RHIB to harm.
> - That duty was breached because Officer One handled the Sir John Chapple in such a way during the chase that he negligently exposed the occupants of the RHIB to risk of harm.
> - That the risk of death and not just the risk of serious injury was a reasonably foreseeable consequence of the way that the RHIB was handled.
> - That the breach caused the deaths. In order for you to be satisfied that this is made out, you have to be satisfied that the actions of Officer One caused the deaths, although they may not be the sole or main cause provided that they contributed significantly to them.
> - That having regard to the risk of death involved, the misconduct was grossly negligent so as to be condemned as a serious crime of manslaughter.

- A breach should only be categorised as gross when it involves such disregard for the life and safety of others as to amount to a crime against the state and deserving punishment.
- That the circumstances of the breach were truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required criminal sanction.

The other verdict that is open to you is accidental death or death by misadventure. If you conclude that death was a result of a coincidence of tragic circumstances and blameless misjudgements, then you are able to return a verdict of death from misadventure."

13 As regards gross negligence manslaughter, the Coroner's direction was derived from "Law Sheet No. 1 Unlawful Killing" produced by the Chief Coroner for England and Wales, dated May 17th, 2013 last revised on January 18th, 2016, in which in particular by reference to *R.* v. *Adomako* (5), the elements of the offence are identified as follows:

> "(1) The existence of a duty of care (based on ordinary principles of negligence) owed to the deceased, (2) a breach of that duty of care, (3) the risk of death (not just the risk of serious injury: R v Misra [2005] 1CrAppR 21 [25] (CA)) was a reasonably foreseeable consequence of the misconduct: Reeves v Commissioner of Police for the Metropolis [2001] 1 AC 360, 393 (HL), (4) the breach caused the death, and (5) having regard to the risk of death involved, the misconduct was grossly negligent so as to be condemned as the serious crime of manslaughter."

14 Unfortunately, evidently unbeknown to counsel and more importantly to the Coroner, the Law Sheet relied upon had by then been superseded by a new version dated September 1st, 2021. No one including the Coroner, who given the inquisitorial nature of inquests must bear particular responsibility, appears to have given thought to the possibility that the law sheet may have been updated, or considered it useful to review the relevant passages in *Archbold* or *Blackstones* for guidance in what as the authorities demonstrate is a complex area of law.

15 The 1 September 2021 Law Sheet identifies *Adomako* (5), *Rose* v. *R.* (10), *Kuddus* v. *R.* (2) and *Misra* (4) as the key authorities of which coroners should be aware, and at para. 20 states:

> "20. *Rose* summarised the six elements of the offence as follows:
>
> (1) The defendant owed an existing duty of care to the victim.
>
> (2) The defendant negligently breached that duty of care.
>
> (3) That breach of duty gave rise to an obvious and serious risk of death.

(4) It was also reasonably foreseeable that the breach of that duty gave rise to a serious and obvious risk of death.

(5) The breach of that duty caused the death of the victim.

(6) The circumstances of the breach were truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required criminal sanction."

Ground 1: duty of care

16 For Officers 1 and 2 it is submitted that the Coroner materially misdirected the jury by limiting the direction in respect of duty of care to "not to act in such a way as to expose the occupants of the RHIB to harm." It is submitted that the scope of the duty of care should have been formulated in terms of exercising "such care and skill as [was] reasonable in all the circumstances" which is the language used by Sir John Donaldson, M.R. in *Marshall* v. *Osmond* (3) ([1983] Q.B. at 1038C), a case which involved a police driver's duty of care to a person endeavouring to avoid arrest.

17 It is submitted by Mr. Hodivala, K.C. that the effect of the direction given by the Coroner was to set a threshold which was too low and that this had four consequences, namely, that:

(i) the jury was wrongly required to consider the duty of care by reference to exposure to risk of harm rather than by reference to whether the officers exercised such care and skill as was reasonable in all the circumstances. Which circumstances can be consistent with exposing individuals to a significant degree of risk;

(ii) the jury could have concluded that the duty not to expose the RHIB's occupants to a "risk of harm" was breached simply by the fact of the collision, rather than whether the collision had occurred despite the officers' exercising reasonable skill and care;

(iii) by failing to require the jury to consider "all the circumstances" when assessing whether the duty had been breached the jury would have focused on the risk of harm when assessing whether the duty had been breached, rather than taking into consideration all of the other factors which were relevant to the assessment of breach of duty; and

(iv) the jury would have assessed the "grossness" of the breach by reference to the risk of harm, rather than by reference to the officers' exercise of reasonable skill and care.

18 *Marshall* v. *Osmond* does not, as I understand it, establish a new specific test which *per se* appertains to police officers, rather in the context of police officers giving chase to suspects it relied upon the notion of "all

the circumstances" as the prism through which the duty of care has to be viewed. Sir John Donaldson, M.R. put it as follows (*ibid.*):

> "The vital words in that proposition of law are 'in all the circumstances,' and of course one of the circumstances was that the plaintiff bore all the appearance of having been somebody engaged in criminal activity for which there was a power of arrest."

19 To put that proposition in context, thereafter dealing with the particular facts of that case, Sir John Donaldson, M.R. said (*ibid.*, at 1038F):

> "As I see it, what happened was that this police officer pursued a line in steering his car which would, in the ordinary course of events, have led to his ending up sufficiently far away from the Cortina to clear its open door. He was driving on a gravelly surface at night in what were no doubt stressful circumstances. There is no doubt that he made an error of judgment because, in the absence of an error of judgment, there would have been no contact between the cars. I am far from satisfied on the evidence that the police officer was negligent."

20 *Marshall* v. *Osmond* (3) was cited with approval by the United Kingdom Supreme Court in *Robinson* v. *West Yorks. Police (Chief Const.)* (9). In *Robinson*, a pedestrian appealed against a decision that the police owed her no duty of care in respect of injuries sustained when a suspect tried to escape arrest in a busy town centre. *Robinson* is *inter alia* authority for the proposition that police officers do not enjoy a general immunity from suit and that they are liable for negligence where such liability would arise under ordinary tortious principles. With the caveats that ([2018] A.C. 736, at para. 75):

> "The Court of Appeal was correct to emphasise the importance of not imposing unrealistically demanding standards of care on police officers acting in the course of their operational duties. That is most obviously the case where critical decisions have to be made in stressful circumstances with little or no time for considered thought. This point has long been recognised."

And (*ibid.*, at para. 76):

> "It is also necessary to remember that a duty to take reasonable care can in some circumstances be consistent with exposing individuals to a significant degree of risk . . . there may be circumstances which justify the taking of risks to the safety of members of the public which would not otherwise be justified. A duty of care is always a duty to take such care as is reasonable in the circumstances."

21 Turning to the present case, the factual matrix is materially different from that in either *Marshall* or *Robinson.* Officers 1 and 2 may have been acting in the belief that they were in BGTW, but the evidence as set out in

Mr. Miekle's expert opinion evidence derived from CCTV operated by WHSS and digital data recovered from the suspect RHIB (as defined by Mr. Miekle) was as set out at 3.3.2 of his report that:

> "the engagement, chase and collision with 'SUSPECT RHIB' were all carried out at least 1.5 NM beyond the limits of BGTW in Spanish waters."

At 3.3.3 he then opined:

> "While the limits of BGTW were not visible to the coxswain on the chart plotter the area of the northern limit of BGTW is generally indicated by reference to the lights from Gibraltar airport. As 'SIR JOHN CHAPPLE' was significantly to the north of the airport and off the Spanish port, it would have been clear to the officers, with significant experience of operating in the area, that they were in Spanish waters and well to the north of BGTW."

22 In my judgment the evidence before the jury as regards the engagement, chase and collision taking place outside BGTW was and is not capable of objective challenge. Nor was there any evidence whatsoever before the jury that the engagement outside BGTW came about consequent upon a hot pursuit from BGTW into Spanish waters in order to stop or arrest beyond BGTW. Irrespective of whether or not Officer 1 or 2 where proceeding in the honest belief based on reasonable grounds that they were engaging the suspect RHIB in BGTW, the incontrovertible evidence before the jury was that when they did so they were in Spanish waters in which they evidently had neither jurisdiction nor powers of arrest.

23 In the absence of any such jurisdiction or powers of arrest it follows that Officers 1 and 2 could not have been acting in the execution of their duty as police officers. Stripped of that authority, in chasing in Spanish waters a vessel suspected of criminal activity the care and skill as was reasonable in all the circumstances was neither more nor less than that of ordinary citizens. Applying the neighbour principle, simply put, a sea-going vessel owes a duty of care to other vessels navigating the same seas.

24 The Coroner's direction as regards the scope of the duty of care owed by the crew of the *Sir John Chapple* to the crew of the suspect RHIB was somewhat stark but nonetheless accurate and sufficient. This was a ground in respect of which I ordered a rolled-up hearing, the relatively low threshold arguability test is met, but for the reasons I have given it fails.

Ground 2: breach of duty

25 The second ground relates to the Coroner's direction as regards breach of the duty of care. The Coroner posed the question whether the duty of care was breached, "because Officer One handled the *Sir John Chapple* in

such a way during the chase that he negligently exposed the occupants of the RHIB to risk of harm."

26 For the claimants it is submitted that this was a circuitous direction by which the jury was directed to consider whether there had been negligence by reference to whether Officer 1 had negligently exposed the occupants of the RHIB to harm. That instead the Coroner should have directed the jury to consider whether specific acts or omissions amounted to a breach of the duty owed by the officers. In relation to this ground reliance is again placed upon the propositions of law which are to be derived from *Marshall* (3) and *Robinson* (9) in relation to the duty of care owed by the police which can in some circumstances be consistent with exposing individuals to a significant degree of risk. Again, it is also submitted that by in effect placing the threshold for the breach of duty too low the jury would have assessed the "grossness" of the breach from an incorrect starting point.

27 For the reasons I have given in respect of the first ground, I discount the submissions in so far as they are premised upon *Marshall* and *Robinson*. However, that of itself does not wholly dispose of this ground.

28 It is right to say that there was an element of circularity in the way in which the jury were invited to determine whether the duty of care had been breached. The focus ought to have been on specific acts or omissions and could have been canvassed in terms of Officer 1's navigation of the *Sir John Chapple*, by reference to the speed at which he was travelling; the manoeuvres undertaken and whether these were reasonable in the circumstances, which included the fact that it was night.

29 That said, in my judgment given the factual matrix, the Coroner's direction did not amount to a material misdirection. Unlike *Kuddus* (2), *Rose* (10) or *Adomako* (5) which were cases of omission, the present is a case involving positive acts by Officer 1 as to how he chose to navigate the *Sir John Chapple*. The Coroner's direction was not as focused as it could have been, but in essence it posed the right question, namely, did Officer 1's navigation of the *Sir John Chapple* breach the duty of care owed to the occupants of the RHIB.

30 In respect of this ground, I also ordered a rolled-up hearing. Again, the relatively low threshold arguable case test is met, but for the reasons I have given it also fails.

Ground 3: foreseeability

31 The submission advanced for the claimants is to the effect that although the Coroner correctly focused the jury's attention on the foreseeability of death (rather than anything less) as a consequence of the police chase and directed the jury to consider whether the risk of death was a "reasonably foreseeable" consequence of the way the RHIB was handled,

he failed to also direct the jury to consider whether they were satisfied that a reasonably prudent person in the position of Officers 1 and 2 would have foreseen that the acts or omissions comprising the breach of duty exposed the deceased to an "obvious and serious" risk of death. That this was an important omission by the Coroner.

The law

32 The requirements for the offence of gross negligence manslaughter were established by the House of Lords in *R.* v. *Adomako* (5) which have been refined in subsequent cases. Relatively very recently, in *Broughton* v. *R.* (1), Lord Burnett, LCJ, handing down the judgment of the court ([2021] 1 W.L.R. 543, at para. 4), referred to *Adomako* and the ingredients of the offence as set out therein and then said (*ibid.*, at para. 5):

> "Gross negligence manslaughter has since been considered in this court on many occasions, particularly within the last four years. The context has frequently been the alleged gross negligence of medical professionals. The appeals include *R v Rudling* (2016) 151 BMLR 79, *R v Sellu* [2017] 4 WLR 64, *R v Bawa-Garba* [2016] Inquest LR 320, *R v Rose (Honey)*, [2018] QB 328, *R v Zaman* [2018] 1 Cr App R (S) 26, *R v Winterton* [2019] 2 Cr App R 12, *R v Pearson* [2019] EWCA Crim 455, *R v Kuddus* [2019] 1 WLR 5199 and *R v Broadhurst* [2019] EWCA Crim 2026. The result of this consideration is that six elements have been identified that the prosecution must prove before a defendant can be convicted of gross negligence manslaughter:
>
> (i) The defendant owed an existing duty of care to the victim.
>
> (ii) The defendant negligently breached that duty of care.
>
> (iii) At the time of the breach there was a serious and obvious risk of death. Serious, in this context, qualifies the nature of the risk of death as something much more than minimal or remote. Risk of injury or illness, even serious injury or illness, is not enough. An obvious risk is one that is present, clear, and unambiguous. It is immediately apparent, striking and glaring rather than something that might become apparent on further investigation.
>
> (iv) It was reasonably foreseeable at the time of the breach of the duty that the breach gave rise to a serious and obvious risk of death.
>
> (v) The breach of the duty caused or made a significant (i e more than minimal) contribution to the death of the victim.
>
> (vi) In the view of the jury, the circumstances of the breach were truly exceptionally bad and so reprehensible as to justify the

> conclusion that it amounted to gross negligence and required criminal sanction.
>
> The elements found in (iii) and (iv) will not need separate consideration or articulation in many cases."

33 For completeness, it is not in dispute that consequent upon *R. (Maughan)* v. *H.M. Senior Coroner for Oxfordshire* (8) the civil standard of proof applies to both narrative and short-form conclusions at inquests where the issue is whether there has been an unlawful killing.

34 Of relevance in the present case the refinements in *Rose* (10) and *Kuddus* (2). In *Rose* an optometrist carried out an eye test examination of a 7-year-old boy. She failed to carry out an adequate internal examination of the eyes and without viewing the optic nerve she could not detect swelling which was present which was an obvious sign of risk of death. The optometrist's conviction of gross negligence manslaughter was quashed because the trial judge had directed the jury to assess whether there was an obvious and serious risk of death, based on knowledge which she would have had, had she carried out an internal eye examination, rather than on the basis of the knowledge which she in fact had. In relation to the core issue of foreseeability Leveson, P. handing down the judgment of the court identified the following principles in relation to foreseeability ([2017] EWCA Crim 1168, at para. 77):

> "(3) The question of whether there is a serious and obvious risk of death must exist at, and is to be assessed with respect to, knowledge at the time of the breach of duty.
>
> (4) A recognisable risk of something serious is not the same as a recognisable risk of death.
>
> (5) A mere possibility that an assessment might reveal something life-threatening is not the same as an obvious risk of death: an obvious risk is a present risk which is clear and unambiguous, not one which might become apparent on further investigation."

35 And (*ibid.*, at para. 78) stated that in assessing either the foreseeability of risk or the grossness of the conduct in question, "[t]he test is objective and prospective" as at the moment of breach, not but for the breach. What falls for consideration is what a reasonable person would reasonably have foreseen and what is required is that the reasonable person would have foreseen an obvious and serious risk of death (*Kuddus* (2) ([2019] EWCA Crim 837, at paras. 35 and 79)).

36 In *Kuddus*, the defendant was the sole director of a company which operated a takeaway food restaurant where he also worked as a chef. The victim ordered a meal via a third-party website, entering "nuts, prawns" in the comments section because she had what was believed to be a mild

allergy to those ingredients. The restaurant received the order but the reference to the victim's allergy was not passed on to the defendant, who prepared part of her meal. The food provided to the victim contained peanut proteins to which the victim suffered a severe allergic reaction and died. The defendant was convicted of manslaughter by gross negligence. On appeal the conviction was quashed on the basis that since the defendant had known nothing of the allergy which the victim had declared, a reasonable person in the position of the defendant would not have foreseen an obvious and serious risk of death by serving her the food that he did.

37 In *Kuddus*, Sir Brian Leveson, P. followed his own judgment in *Rose* (10). The principles which can be derived from *Kuddus* and which are of relevance in these proceedings are commendably summarized in the claimants' skeleton argument with cross references to paragraph numbers in *Kuddus*, as follows:

"a. The criminal law of [gross negligence manslaughter] differs from the civil law of negligence when it comes to [proof of a foreseeable risk of death]: [44];

b. The criminal law requires that a reasonably prudent person possessed of the information known to the defendant would have foreseen that the defendant's actions or omissions constituting the breach of duty had exposed the deceased to an 'obvious and serious' risk of death. The risk of death is linked to, but separate from, the further assessment whether the negligence was 'gross': [45]–[48];

c. What must be reasonably foreseeable is a 'serious and obvious' risk of death of the person to whom the defendant owed the duty (referring to the principle in Rudling that 'a recognisable risk of something serious is not the same as a recognisable risk of death': [49];

d. Assessment of the seriousness of the breach of duty should take into account all the circumstances in which the defendant was placed when the breach occurred: [50];

e. Whether it is foreseeable that there is a serious and obvious risk of death must exist at, and be assessed by reference to, information available to the defendant at the time of the breach of duty: [51];

f. 'Serious and obvious' risk of death is not proved by the fact of death: [52];

g. The defendant's breach of duty must give rise to (1) a risk of death, that was (2) obvious and (3) serious. These are objective

facts that are not dependent on the defendant's state of mind: [53];

h. In any case of [gross negligence manslaughter] there is, by definition, a risk of death, because it must be proved that the defendant's breach caused the death of the victim. Whether the risk of death was obvious is also a question of fact. The risk is important in two contexts: first, whether the risk would be foreseen by a prudent person standing in the shoes of the defendant; and second, for the jury to take into account when considering whether the defendant's breach was so serious that it should be regarded as criminal. The seriousness of the risk of death, as an objective fact, is itself a question of fact and is distinct from the question whether a reasonable person in the defendant's position should have foreseen that the risk was serious and obvious. You cannot foresee something that does not exist: [54]."

And

"If a reasonable person possessed of the knowledge available to the defendant would have foreseen only a chance that the risk of death might arise, that is not enough to justify a conviction for [gross negligence manslaughter] . . . [79]."

Discussion

38 Adopting the numbering of the elements as identified in *Broughton* (1) at para. 32 above, it is self-evident that the Coroner failed to direct the jury fully in relation to elements (iii) and (iv). He did not treat these as distinct elements, although as *Broughton* makes clear in many cases these two elements do not require separate articulation or consideration. He also failed to introduce the "serious and obvious risk of death" threshold in his direction to the jury in respect of reasonable foreseeability of risk of death. I accept the submission advanced for the claimants that the "obvious and serious" requirement was relevant to the jury's deliberations, not only with regards to foreseeability but also grossness of the breach of duty.

39 In short, there are therefore two related but distinct issues which arise in relation to the Coroner's direction, namely:

(a) the failure to give a direction in line with ingredient (iii) in *Broughton*, and

(b) the failure to include the words "obvious and serious" when directing the jury as to foreseeability,

bearing in mind the related but distinct impact which any such misdirection may have had upon the assessment of grossness of the breach. Thereafter,

the overarching question is whether any such misdirection would have affected the outcome of the inquest such that the inquest verdict should be set aside.

40 As regards that last question, the test that is to be applied is whether it is necessary or desirable in the interests of justice that relief should be granted (*per* Lord Woolf, M.R. in *R. (Douglas-Williams)* v. *Inner South London Coroner* (6) ([1999] 1 All E.R. at 347)). That judgment was followed by our Court of Appeal in *R. (Francis)* v. *H.M. Coroner* (7). Tuckey, J.A. said (2010–12 Gib LR 71, at para. 4):

> "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* . . .
>
> > '(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.'
> >
> > If a misdirection would not have affected the outcome, then the inquest should not be set aside.'"

41 It is possibly not mere chance that very many of the authorities in which the issue of gross negligence manslaughter generally and foreseeability in particular have been considered have involved deaths in which negligent medical treatment was causative. Cases such as *Rose* (10), *Misra* (4), and *Kuddus* (2) (although not a medical negligence case) are illustrative of the difficulties which can arise in relation to foreseeability of death where a duty of care is breached. The factual matrix which was before the inquest jury in the present case is very different. The deaths of Mohamed Abdeslam Ahmed and Mustafa Dris Mohamed came about as a consequence of a collision between two very high powered vessels involved in a high speed pursuit; at very close range; in the dark; in which the RHIB was not displaying any lights (navigational or otherwise); in which objects were thrown by the occupants of the RHIB to obstruct or impede the *Sir John Chapple*; in which the RHIB made evasive manoeuvres crossing the path of the *Sir John Chapple* spraying water onto it thereby reducing the visibility of Officer 1. Moreover, this in the context that the evidence which was before the jury was that although RGP Marine Section coxswains are

trained in pacing manoeuvres, no specific training in high-speed pursuits is provided.

42 It is said on behalf of Officers 1 and 2 that it was their evidence that they believed the pursuit was conducted with a safe distance between the *Sir John Chapple* and the RHIB and that therefore the issue for the jury was not simply whether this was correct as a matter of fact, but whether any failure to do so gave rise to nothing less than a serious and obvious risk of death. That submission was developed by the assertion (which I understand was in evidence before the inquest jury) that prior to the incident, in the period 2017–2020, the RGP Marine Section had conducted 59 previous pursuits, with Officer 1 involved in a number of these and that there had never been a collision or fatality. In my judgment the reliance upon the absence of past incidents or fatalities is a wholly insufficient answer. Rather, it is self-evident that navigation in the manner described above creates a serious and obvious risk of death and the absence of specific training in high-speed pursuits clearly points to the fact that they are inherently extremely dangerous.

43 The evidence before the jury was such that no legitimate criticism can be levied against the Coroner for leaving the verdict of unlawful killing to the jury. Moreover, given the factual matrix, and had he given thought to it, he could properly have considered it unnecessary to deal with elements (iii) and (iv) in *Broughton* (1) distinctly. The issue for determination was that of reasonable foreseeability. The Coroner's failure was therefore limited to his directing the jury to consider whether there was a "risk of death" as opposed to a "serious and obvious risk of death." That misdirection impacts upon the foreseeability test and upon grossness of the breach. As regards the latter, the failure was very materially mitigated by the Coroner's reiterated direction as to grossness, with the last three bullet points of his directions dealing with this. That therefore in effect leaves the absence of the words "serious and obvious" in the direction as to foreseeability as the basis upon which to set aside the inquest verdict, that is to say a failure to address a refinement of *Adomako* (5). In my judgment this was a case in which there was overwhelming evidence of a serious and obvious risk of death and that consequently such risk was reasonably foreseeable at the time of the breach. In all the circumstances the limited misdirection would not have affected the outcome of the inquest and there is no real risk that justice has not been done or seen to be done. The challenge under ground 3 is also dismissed.

Conclusion

44 For these reasons this application for judicial review is dismissed and the inquest jury's verdict stands. I shall hear the parties as to costs.

Application dismissed.