



Albion Chambers INQUEST TEAM NEWSLETTER

Coroners and Galbraith

A cautionary tale

The inquisitorial nature of coronial proceedings places a considerable burden on coroners, both in terms of making findings of fact and also applying the law to those findings. One area where the decision-making process can be particularly difficult is in deciding the issue of which short form verdicts should be left for consideration at the conclusion of the evidence.

Before the decision is made the parties to proceedings will inevitably make submissions. These will be designed to try and prevent the risk of an unfavourable finding. The area where there is most argument is that of unlawful killing.

The recently decided authority of *Secretary of State for Justice, R (on the application of) v HM Deputy Coroner for the Eastern District of West Yorkshire & Ors* [2012] EWHC 1634 (Admin) (14 June 2012) illustrates the difficulties that this issue can cause. It is of particular interest because the coroner decided to leave unlawful killing to the jury on two bases: gross negligence manslaughter and murder.

Facts

In the early hours of 28 September 2007, a prisoner ("KO") died in his single cell at HM Prison Leeds. He was found by prison officers on duty apparently hanging, or partially suspended, from his bed sheet, one end of which was wrapped round his neck and the other end tied to the window bars above him. There was no sign of disturbance or struggle in the cell. He had a significant ligature mark round his neck. A police

investigation found no evidence of any third party involvement in his death. A post mortem and forensic examination was carried out and the pathologist, Professor Milroy of Pinderfields Hospital, Wakefield, confirmed self-inflicted death by hanging with a bed sheet.

KO was an Ethiopian national. He was married with two young children, had come to the United Kingdom in 2003 and made an unsuccessful asylum application. He spoke limited English. The three months before his death had been traumatic. On 30 June 2007, he had been arrested for the murder of his wife. She had suffered multiple stab wounds. He had sustained serious knife wounds to his hands. His children had witnessed the attack. He was arrested at the scene and told police that he would kill himself at the first opportunity.

KO was remanded in custody to HMP Leeds on 4 July 2007. He was immediately admitted to the Healthcare Centre at HMP Leeds because of the injuries to his hands. He was also placed on the ACCT ("Assessment, Care in Custody and Treatment") programme because he was a known suicide risk. Initially, he refused surgical treatment for his injuries, which included ligament damage, but then relented, and on 12 July 2007 underwent surgery at Leeds General Infirmary. He was returned to the Healthcare Centre with his hands in plaster and heavily bandaged, and required considerable assistance. He was taken off the ACCT on 18 July 2007, by which time he maintained that he no longer had any suicidal thoughts. Whilst in the Healthcare Centre, KO had asked repeatedly about his children who had

witnessed their mother's death. He was told he would not be permitted to see them. He was distressed about this and concerned for their welfare. He was invited to write to them.

KO remained at the Healthcare Centre until 27 August 2007. He was then moved to an ordinary wing at HMP Leeds, 'C' Wing, which houses some 220 prisoners. HMP Leeds houses some 1,200 prisoners in total.

The Inquest

The hearing was conducted as an "enhanced" inquest pursuant to Article 2 of the ECHR. At its conclusion there were the usual arguments as to verdicts. The coroner left the expected verdicts of "accidental death", "suicide" and an "open verdict". She also decided to leave verdicts of murder and unlawful killing by gross negligence manslaughter. Unsurprisingly those affected by the findings immediately sought to challenge them by way of judicial review and the inquest was adjourned pending the appeal.

Coroner's rationale for making the disputed findings

In respect of both findings the coroner purported to direct herself in accordance with Galbraith. It was probably her failure to apply the test properly that led to the appeal.

Murder

The coroner's reasons for leaving unlawful killing by way of murder to the jury essentially relied upon the evidence of two witnesses.

First, the evidence of the next door inmate, Driver, who gave evidence that he woke up during the night around 1 to 2 a.m. and heard a 'commotion' in KO's cell.

Second, the evidence of the reviewing pathologist Dr Richard Shepherd. The Deputy Coroner pointed to a number of aspects of Dr Shepherd's evidence from which the jury might conclude that the bed sheet was not the operative ligature and, therefore, "another method of asphyxiation

was employed, and [KO]'s purported suicide was, in blunt terms, staged, which argument inevitably points to third party involvement...". The Deputy Coroner referred, in particular, to Dr Shepherd's evidence that:

(1) the fracture to KO's voice-box was consistent with significant force being applied in that area, whether by hanging or ligature strangulation or manual strangulation;

(2) the 'looping' of a bed sheet was an unusual mechanism for hanging;

(3) the ligature mark had features which tended to point away from the bed sheet;

(4) KO had two additional abrasions, neither of which was consistent with the simple application of a noose round the neck made from a bed sheet, and one of which was unlikely to have been self-inflicted.

Gross negligence manslaughter

The Deputy Coroner's reasons for leaving unlawful killing by way of gross negligence manslaughter to the jury were, in summary, that there was evidence upon which the jury could conclude that KO had taken his own life because of bullying by other prisoners, which had been caused by rumours that he was a sex offender spread by a number of prison officers. The Coroner referred to several aspects of the evidence.

Firstly, a 'mass' of evidence regarding KO's general vulnerability and evidence that a number of prison officers had knowledge of his ACCT file.

Second, evidence that KO had been subjected to 'bullying' by fellow inmates as a result of rumours on 'C' Wing that he was a 'sex offender' which three prison officers, Adam Kitching, Amanda Whittaker and Bernica Williams (the Third, Fourth and Fifth Interested Parties) had been involved in spreading.

Third, evidence from another prisoner, Phillips (now dead), that KO had told him he was 'scared' in prison.

Fourth, evidence that being labelled a 'sex offender' could make life unbearable in prison (and this was a foreseeable consequence of spreading such rumours).

The basis of the Appeal

Those affected by the ruling argued that there was no basis for these findings on the evidence. Accordingly the verdicts could not, as a matter of law be left. A distinction was drawn between the application of the principles of *R v Galbraith* in the criminal courts 'Pure Galbraith' and in the coroner's court 'Galbraith plus'.

The Law

The classic *Galbraith* test as laid down by Lord Lane CJ in *R v Galbraith* (1981) 73 Cr. App. R. 124, CA, is as follows:

"(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.

(2) The difficulty arises where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence.

(a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.

*(b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury. **It follows that we think the second of the two schools of thought is to be preferred.** There will of course, as always in this branch of the law, be borderline cases. They can safely be left to the discretion of the judge."* (emphasis added)

The two 'schools of thought' referred to by Lord Lane, of which the CA in *Galbraith* preferred the second, were explained earlier in the judgment:

"There are two schools of thought:

(1) that the judge should stop the case if, in his view, it would be unsafe (alternatively unsafe or unsatisfactory) for the jury to convict;

(2) that he should do so only if there is no evidence on which a jury properly directed could properly convict.

Although in many cases the question is one of semantics, and though in many cases each test would produce the same result, this is not necessarily so. A balance has to be struck between on the one hand a usurpation by the judge of the jury's function and on the other the danger of an unjust conviction."

The authorities recognise that there is some (if small) distinction between the position of a coroner deciding what verdict to leave to a jury after hearing all the evidence and that of a judge in a criminal trial considering whether to stop a case after the conclusion of the prosecution case.

This was made clear by Waller LJ in *R (Bennett v HM Coroner for Inner South London* [2007] EWCA Civ 617). Waller LJ cited passages of Lord Woolf MR in *R v HM Coroner for Exeter, Ex Parte Palmer* [1997] CA (10 December) and Leveson J in *Sharman v HM Coroner for Inner North London* [2005] EWHC 857 (Admin) and made the following observation (at paragraph [29]):

"The emphasis seems to be on the safety of leaving a particular verdict to the jury".

Waller LJ went on to note that the very issue in *Galbraith* was which of the 'two schools of thought' was to be preferred. He cited the two 'schools of thought' passage from *Galbraith* set out above and, after observing that the CA in *Galbraith* preferred the second school of thought ("*...no evidence on which a jury properly directed could properly convict...'*") to the first ("*...unsafe or unsatisfactory for the jury to convict...'*"), said as follows:

*"[30.] But the language of Lord Woolf and Leveson J, so far as coroners are concerned would seem to be nearer the rejected school of thought, albeit Woolf was saying that a coroner should not "decide matters which are the province of the jury". I would understand the essence of what Lord Woolf was saying is that coroners should approach their decision as to what verdicts to leave on the basis that facts are for the jury, **but they are entitled to consider the question of whether it is safe to leave a particular verdict on the evidence to the jury**, i.e. to consider whether a verdict, if reached, would be perverse or unsafe and to refuse to leave such a verdict to the jury."* (emphasis added)

Waller LJ held on the facts of that case that the coroner was right to take the view that a verdict of unlawful killing could not be safely left to the jury in that case (see paragraph [34]).

It is clear, therefore, that when coroners are deciding whether or not to leave a particular verdict to a jury, they should apply a dual test comprising both limbs or 'schools of thought', i.e. coroners should

(a) ask the classic pure *Galbraith* question "*Is there evidence on which a jury properly directed could properly convict etc.?*" (see above) plus

(b) also ask the question "*Would it be safe for the jury to convict on the evidence before it?*".

The second limb provides a wider and more subjective filter than the first in certain cases. Arguably, this extra layer

of protection makes sense in the context of a coronial inquiry where the process is inquisitorial rather than adversarial, the rights of interested parties to engage in the proceedings are necessarily curtailed and coronial verdicts are at large.

Coroner's approach

An analysis of the reasoning of the coroner showed that she had failed properly to direct herself on the issue of whether or not it "would be safe for the jury to convict on the evidence before it" and accordingly her decision to leave the two disputed verdicts to the jury was fundamentally flawed.

Findings

It is interesting to look briefly at the findings that were made in respect of the two allegations. In respect of murder the relevant findings were:

1. There was no evidence at all as to any motive or rationale for murder.
2. There was no sign of any struggle in the cell.
3. The finding of the original forensic pathologist was unequivocal: death was "due to self suspension hanging" with the use of a bed sheet. No other ligature was found in the cell, save the bed sheet.

It would seem that if this were the totality of the evidence there was no basis of leaving murder as a verdict whichever "Galbraith" approach was applied!

The findings on gross manslaughter were considered against the requirements set out in *R v Adomako* [1995] 1AC 171;

"... in 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 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 is fatal to its being correct as a test of how far conduct must depart from 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."

With the exception of one prison officer where a breach of duty of care was found, there was no evidence of any of the other relevant constituent elements of gross negligence manslaughter. Accordingly that offence could not have been left to the

jury whichever "Galbraith" approach was applied.

Conclusion

The coroner was faced with what were described as "novel issues of significant complexity at short notice in a complex and lengthy inquest". The issues would, however, have been more clearly analysed had the coroner appreciated that she was entitled to free herself from the shackles of pure Galbraith and examine the quality of the evidence available and to ask whether a verdict returned upon it could be said to be safe.

Stephen Mooney

Appealing the decisions of a coroner

It had been hoped that the Coroners and Justice Act 2009 would provide a clearly defined route by which coroners' decisions could be challenged. In fact a specific section dealing with this issue was included in the Act. S. 40 provided for a new system of appeal against some decisions and determinations made in connection with investigations and inquests into deaths. This section was never brought into effect and has now been quietly killed off by S.33 of the Public Bodies Act 2011. What then are the methods available to remedy perceived errors made by a coroner in the course of an inquest?

Section 13 applications

Section 13 of the Coroners Act 1988 is the first port of call if there is a decision not to hold an inquest or if there is a fundamental defect in particular proceedings.

It provides that if the High Court is satisfied either:

1. that the coroner is refusing or neglecting to hold an inquest which ought to be held, or;
2. where an inquest has been held, that it is necessary or desirable in the interests of justice that another inquest be held, then the High Court may order an inquest to be held by the same or another coroner, order the coroner to pay

such costs as appear just, and quash the verdict of the original inquest, if one took place.

An application to the High Court must be made or authorised by the Attorney-General, i.e with his "fiat".

S.13 does not specify a time limit and accordingly can be invoked if it becomes apparent, for example, that the coroner has failed to take into account significant evidence, or if new evidence becomes available that could have a fundamental bearing on the findings made.

Judicial review

The authority examined elsewhere in this newsletter (*R (on the application of) v HM Deputy Coroner for the Eastern District of West Yorkshire & Ors* [2012] EWHC 1634 (Admin) (14 June 2012) demonstrates the importance of this remedy.

The grounds upon which a coroner's decision or inquest verdict may be challenged by way of Judicial Review are based upon public law principles. These are concerned with the fairness of the procedure and whether the coroner has properly exercised his or her powers.

If a coroner has acted unreasonably, either outside his or her powers or by not doing something which (s)he was obliged to do, it may be possible to seek judicial review of the coroner's actions (or inactions).

The principle remedies that will be

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Call 1987



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Paul Cook
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Jason Taylor
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Kirsty Real
Call 1996



Kate Brunner
Call 1997
Recorder
Team Leader



Richard Shepherd
Call 2001



Stuart Fuller
Call 2007

Team Clerks Nick Jeanes and Michael Harding

applicable to Judicial Review of coronial decisions are Quashing, Prohibiting and Mandatory Orders:

1. Quashing order;

A quashing order nullifies a decision which has been made by the coroner. The effect is to make the decision completely invalid. Such an order is usually made where the coroner has acted outside the scope of his powers ('ultra vires'). The most common order made in successful judicial review proceedings is a quashing order. If the court makes a quashing order it can send the case back to the coroner directing him to remake the decision in light of the court's findings. Very rarely, if there is no purpose in sending the case back, the High Court may take the decision itself.

2. Prohibiting order;

A prohibiting order is similar to a quashing order in that it prevents a coroner from acting beyond the scope of his powers. Examples of where prohibiting orders may be appropriate include stopping the implementation of a decision in breach of natural justice.

3. Mandatory order;

A mandatory order compels a coroner to fulfill his duties. Whereas quashing and prohibition orders deal with wrongful acts, a mandatory order addresses wrongful failure to act.

There is a time limit for bringing an application for judicial review (normally no later than within three months of the decision to be challenged). It is particularly important to pay attention to this time limit. The Administrative Court does not regard it as a maximum that applies to every case. The court has refused to grant

permission to seek judicial review where the application has been lodged within the three-month time period but not as promptly as it could have been.

It is also of note that Judicial Review is a process that can be used to challenge interlocutory decisions made during an inquest.

Human Rights Act challenge

If a coroner makes a decision which is inconsistent with the European Convention on Human Rights, an individual affected by that decision may be able to seek a remedy before the High

Court. A different and generally longer time limit applies.

It is unfortunate that the S.40 appeal process was abandoned. It represented an opportunity to consolidate and clarify appellate proceedings in the area of Coronial Law. Unless or until a further review of proceedings is carried out practitioners will need to be familiar with the various routes of appeal highlighted in this article and ensure that when a questionable decision is made, the most appropriate route is followed with the required speed.

Stephen Mooney

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