IN THE COURT OF APPEAL FOR GIBRALTAR

Neutral Citation Number 2024/GCA/007

2023/CACIV/007

BETWEEN:

(1) "OFFICER 1" and

(2) "OFFICER 2"

Appellants/Cross-Respondents

and-

HIS MAJESTY'S CORONER FOR GIBRALTAR

First Respondent

THE ROYAL GIBRALTAR POLICE

Second Respondent/Cross-Appellant

IRENE CAMPELLO CHICON

Third Respondent

Jamas Hodivala KC and **Darren Martinez** (instructed by **Hassans**) for the **Appellants/Cross-Respondents**

Neil Costa and **Kyle Bautista (**instructed by **Isolas**) for the **Second Respondent/Cross-Appellant**

Christopher Finch (instructed by **Verralls**) for the **Third Respondent**

Judgment date: 19 April 2024

JUDGMENT

SIR MAURICE KAY, P:

1. In the early hours of 8 March 2020 a Royal Gibraltar Police vessel (RGPV) was giving chase to a rigid hulled inflatable boat (RHIB). The chase ended with a collision. Two of the occupants of the RHIB, Mohammed Abdeslam Ahmed and Mustafa Dris Mohammed, died as a result of the collision. On 26 November 2021, following an inquest held over nine days before HM Coroner Charles Pitto, the jury found that both deceased died of multiple injuries sustained in the collision which had occurred outside British Gibraltar Territorial Waters (BGTW), but within Spanish waters. The verdicts were that both deceased had been unlawfully killed.

2. Two of the police officers involved in the RGPV, referred to as Officer 1 and Officer 2, commenced judicial review proceedings in which they challenged the unlawful killing verdicts. In essence they claimed that the Coroner had misdirected the jury in various ways. In a judgment handed down on 19 April 2023 the Chief Justice, although finding that there had been misdirection to some extent, concluded that it would not have affected the outcome of the inquest and that there was *"no real risk that justice has not been done or seen to be done"*. The application for judicial review therefore failed.

3. By grounds of appeal dated 22 May 2023, Officer 1 & Officer 2 (the Appellants) seek to set aside the Chief Justice's Order and continue to contend for the quashing of the unlawful killing verdicts.

4. The verdicts were based on gross negligence manslaughter. The Coroner had left two possible verdicts for the consideration of the jury – unlawful killing by reason of gross negligence manslaughter or death by misadventure. It is not suggested that the choice of possible verdicts was inappropriate. The case for the Appellants is that the Coroner misdirected the jury in the terms in which he dealt with, in particular, gross negligence manslaughter. Moreover, it is submitted that the misdirections were not such as can be categorised as "*immaterial*".

Gross Negligence Manslaughter

5. Before turning to the Coroner's directions, it is necessary to set out the ingredients of gross negligence manslaughter in a case such as this. In *Adomako* [1995] AC 1, Lord Mackay of Clashfern LC, having traced the modern law back to *Bateman* (1925) 19 Cr. App. R. 8 and, particularly, *Andrews v DPP* [1937] AC 576, expanded the law in these terms (at page 187):

> *"…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 …, was such that it should be judged criminal."*

We have been referred to a number of more recent authorities which have considered the principles, many of them in the context of the alleged gross negligence of clinicians. Drawing the strands together in *Broughton* [2020] EWCA Crim 1093, Lord Burnett CJ said (at paragraph 5):

> *"…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."

From time to time successive Chief Coroners for England and Wales have published guidance to Coroners reflecting developments in the law as articulated in appellate judgments. The current guidance is to be found in Law Sheet Number 1 published by the Chief Coroner on 1 September 2021. It reflects the six principles set out in *Broughton,* albeit taken from the earlier authority of *Honey Rose* [2018] QB 328.

The directions of the Coroner in the present case

6. Before directing the jury, the Coroner produced a draft of his proposed directions. Whether in their original or an amended form, they were agreed by counsel then appearing (who did not at that time include either Mr Jamas Hodivala KC or Mr Martinez) before the Chief Justice and before us. Much of this appeal is concerned with a critique of the Coroner's directions. It is therefore necessary to set them out in some detail. They included these passages:

"In order to return a verdict of unlawful killing you must be satisfied on a 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 (RGPV) a duty not to act in such a way as to expose the occupants of the RHIB to harm.

That duty of care was breached because Officer 1 handled the (RGPV) in such a way during the chase that he negligently exposed the occupants of the RHIB to the risk of harm.

> *That the risk of death, and not just the risk of serious injury, was a reasonably foreseeable consequence of the way 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 actions of Officer 1 caused the deaths although they need not be the sole or main cause provided that they contribute significantly to them.*
>
> *That having regard to the risk of death involved, the misconduct was grossly negligent so as to be condemned as the 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 which is open to you is accidental death or death by misadventure. If you conclude that the death was the result of a tragic coincidence of circumstances and blameless misjudgements then you are able to return a verdict of death by misadventure. You should also return this verdict if you find that the deaths were negligently caused but you are not satisfied that the negligence could be classified as gross negligence deserving of punishment".*

That these directions were agreed by counsel at the inquest is a point now taken by the Interested Parties in seeking to resist the appeal. However, if the directions were legally flawed in a material way or ways, the fact that they were agreed or not objected to at the time cannot protect them from correct analysis in this court. If authority for that proposition is needed, it is illustrated by *R v HM Coroner for the County Borough of Neath & Port Talbot* [2006] EWHC 2019 (Admin) at paragraph 60 per Bennett J.

The facts

7. The inquest lasted 9 days. Evidence was received from some thirty witnesses, most of them providing oral testimony. Given the nature of coronial procedure, it is difficult for a reviewing court to know precisely

what factual findings were made by the jury beyond the brief formal findings required by the Coroner Act. From these we know that the jury found that the fatal collision occurred at about 02:45am on 8 March 2020 in Spanish territorial waters. Apart from the crew of the RGPV, the most important witness was probably Mr Richard Miekle of Solis Marine Consultants, an expert who produced a detailed report which he read to the jury and upon which he was questioned by counsel and the Coroner. The Chief Justice set out extensive passages from the report in his judgment. Indeed the report seems to have been the main source of the statement of facts and detailed grounds attached to the claim form for judicial review. I shall resort to it in attempting to reconstruct what happened.

8. There is an established drugs trade between Morocco, Spain and Gibraltar in which RHIBs are the vessel of choice for drug importers. The RHIB in this case was unregistered. Significant efforts had been made to ensure that no lights were visible, including the dashboard display and indicator lights which had been taped over to conceal them during use. On the night of 8 March, the RGPV was on routine patrol. At about 2:35am a suspect RHIB was seen heading towards the Spanish port of Puerto de la Atunara. A mobile phone call was received by the RGP Marine Section reporting that there was an unknown vessel without navigation lights heading towards the coast. Officer 1, coxswain on the RGPV, called the Spanish Guardia Civil and relayed the information. The report was confirmed by the Guardia Civil, whereupon Officer 1 confirmed that he would deploy to the east side of Gibraltar. The radar was turned on but the GPS chart-plotter was left off, as Officer 1 felt that it reduced his night vision. This meant the vessel's AIS, which is linked to the chart-plotter was not on. As the RGPV arrived on the eastern side of Gibraltar, Officer 1 received a call from the Guardia Civil updating him on the RHIB's movements. He was instructed to head to the east of the port and wait. The RHIB that was by the Atunara port, had four crew on board. They were informed of the presence of the RGPV by "spotters" ashore. The RHIB then headed away from the Spanish coast. Officer 1 was instructed by the Guardia Civil to remain in position, as the RHIB was heading directly for that location. When the RHIB was viewed

on the RGPV's radar as being within 0.25 nautical miles, Officer 1 turned on his blue beacon lights to inform the RHIB of their presence. Officer 1 stated that the RHIB passed between 5 to 10 metres in front of the RGPV's brow, whereupon a high speed pursuit commenced.

9. Officer's 1 evidence was that the intention was to identify those on board the RHIB and determine whether the RHIB was carrying illegal cargo. The RHIB was not displaying any lights (navigational or otherwise). Officer 1 thought that the RHIB was heading towards Morocco. He approached the RHIB's port side and Officer 2 shone his dragon torch on the vessel. As is a common tactic used by smugglers, objects were thrown by the occupants of the RHIB.

10. During the pursuit, the RHIB made numerous sharp turns, spraying seawater onto the RGPV 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. 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. Officer 2 stated that the RHIB had passed very close to RGPV and that spray had reduced visibility from the windows. There was a sudden collision that caused the RGPV to stop abruptly. It began to tilt to starboard, and water began to flood into the vessel. It appears that the RGPV had collided with the near left hand side of the RHIB and had partially gone over it. One of the crew of the RHIB died instantly and another received fatal injuries resulting in his death shortly afterwards. The RGPV had a saw-like device fitted to its prow of a kind commonly used in countries such as Canada in the logging industry for the clearing of debris. Although the collision occurred in Spanish Territorial waters, Officers 1 and 2 maintain that they thought they were in BGTW. They had received no complaint from the Spanish authorities that they were in Spanish Territorial waters. No illicit cargo was found on the RHIB.

11. This factual account is taken mainly from Mr Miekle's report. Much of it is not controversial although some of it may be disputed by one party or another.

Ground 1: Errors in the identification of the scope of the duty of care for the purposes of gross negligence manslaughter

12. When directing the jury the Coroner said that for there to be unlawful killing verdicts it had to be established on a balance of probabilities that the crew of the RHIB were owed a duty of care by the crew of the RGPV:

> *"not to act in such a way as to expose the occupants of the RHIB to harm (and) that the duty of care was breached because Officer 1 handled the (RGPV) in such a way during the chase that he negligently exposed the occupants of the RHIB to the risk of harm"*.

Mr Hodivala submitted that this formulation erroneously ignored the law on the duty of police officers when investigating suspected criminality, as propounded in the authorities, in particular *Marshall v Osmond* [1983] QB 1034 and *Robinson v Chief Constable of West Yorkshire Police* [2018] AC 736. In *Marshall*, Sir John Donaldson MR said at page 1038:

> *"I think that the duty owed by a police driver to the suspect is … the same duty as that owed to anyone else. Namely to exercise such care and skill as is reasonable in all the circumstances. 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 of the appearance of having been somebody engaged in a criminal activity for which there was a power of arrest… 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. But I am far from satisfied on the evidence that the police officer was negligent".*

This approach was expressly approved by the United Kingdom Supreme Court in *Robinson*, where Lord Reed (with whom Baroness Hale and Lord Hodge agreed) said at paragraph 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. That is most obviously the case in relation to the police themselves. There are many circumstances in which police officers are exposed to a risk of injury, but in which such exposure is consistent with the taking of reasonable care for their safety. Equally, 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".*

Lord Hughes added (at paragraph 121):

> *"Of course, where action is brought on the basis of physical harm done by a positive act of the police, it will succeed if, but only if, negligence is proved. As Lord Reed JSC explains at paragraph 75, policing may sometimes involve unavoidable risk to individuals. It may very often involve extremely delicate balancing of choices. Crowd control, hostage situations, violent outbreaks of crime and the allocation of scarce resources where there are large numbers of persons with the potential to offend, even at the terrorist level, are simply examples. Sometimes decisions may have to be made under extreme pressure; at other times they may remain very difficult notwithstanding time for analysis, and there may be a high level of risk that they turn out to be wrong. The question is always not whether, with hindsight, the decision was wrong, but whether in all the circumstances it was reasonable."*

Such considerations were conspicuously absent from the Coroner's directions to the jury in the present case. His words were tantamount to saying that exposing the occupants of the RHIB to risk of harm could amount to breach to the duty of care. When this was explained to the Chief Justice, he purported to distinguish *Marshall* and *Robinson* on the basis that the collision had occurred in Spanish territorial waters: therefore the officers, being beyond the jurisdiction and not having the power of arrest, were no longer acting in the execution of their duty, irrespective of whether they believed that they were still in GBTW. This had the consequence that *"the care and skill as was reasonable in all the circumstances was neither more nor less than that of ordinary citizens"* (paragraph 23). In my

judgment, the suggestion that, as soon as a police officer exceeds his lawful authority he automatically forfeits the protection afforded by the *"all the circumstances"* analysis propounded in *Marshall v Robinson,* is incorrect. This is demonstrated by, for example, *Sobczak v DPP* [2012] EWHC 1319 (Admin), which makes it clear that a police officer who trespasses in the course of investigating a crime, may still be acting in the course of his duties: see paragraphs 20 to 22 per Mitting J. Similar considerations would arise if for example a police driver in the course of a chase went the wrong way up a one way street. Whether or not he acted in breach of his duty would still fall to be assessed by reference to "all the circumstances of the case", including the realities of a fast developing situation. I refer again to the passages from the judgments of Lord Reed and Lord Hughes in *Robinson.* The error in the Chief Justice's approach is that is it based on a retrospective analysis of conduct, rather than on a prospective consideration of the duty, by reference to the functions being discharged at the time and in all the circumstances.

13. It is mainly for these reasons that I consider that the Chief Justice was wrong to consider that on this issue the Coroner's directions were "*accurate and sufficient*". In my view they were not. They were manifestly erroneous. Moreover, the shortcomings were compounded when the Coroner spoke of breach of duty in the context of Officer 1 having handled the RGPV in such a way that "*he negligently exposed the occupants of the RHIB to the risk of harm"*. Having failed to give a proper direction on breach of duty, the direction he gave by the use of the word "*negligently*" was more confusing than enlightening.

Ground 2: Failure to direct on particular acts and omissions

14. There is a degree of overlap between this ground of appeal and ground 1. One side of the coin was the Coroner's error as I have found it to be in directing the jury to consider whether there had been a breach of duty by reference to whether Officer 1 had exposed the occupants of the RHIB to

harm. That was an express misdirection. The other side of the coin is in the form of a submission that the Coroner ought to have assisted the jury by directing their attention to specific alleged acts and omissions, which might separately or together establish a relevant breach of duty. The Chief Justice was astute to observe (at paragraph 29) that, "*the Coroner's direction was not as focussed as it could have been",* and (at paragraph 28) that the focus ought have been on "*specific acts and omissions*". However, he concluded that the direction "*in essence posed the right question, namely, did Officer 1's navigation … breach the duty of care owed to the occupants of the RHIB".* I consider that this conclusion was too generous to the Coroner. Coronial proceedings pose particular difficulties. Jurors do not receive the kind of clarification of issues which opening and closing speeches provide in adversarial criminal proceedings. It is therefore essential, particularly in a complex case of alleged gross negligence manslaughter, that the coroner explains to them with clarity the acts and omissions which might support a finding of breach of duty. In *R (Anderson) v HM Coroner for Inner North Greater London* [2004] EWHC 2729 (Admin) Collins J. said (at paragraph 22):

> *"… the jury must know clearly what they must find as facts in order to justify any verdict, especially one which decides that a criminal offence has caused the death. The law must always be applied to the facts of a given case. A general direction is usually not sufficient and may be misleading".*

It seems to me that the Coroner's direction on breach of duty in the present case was both insufficient and misleading. He not only lowered the bar by his direction on exposing the occupants of the RHIB to risk (with its overtones of a retrospective analysis); he failed to specify or particularise acts or omissions which might amount to breaches of duty. This created or increased the possibility that the jury might fall into the trap of working backwards from the fact of the fatal collision to a vague assumption that it must have been caused negligently. I therefore conclude that this ground of appeal succeeds.

Ground 3: Misdirection on "serious and obvious risk of death"

15. The third and fourth elements of gross negligence manslaughter are that "(iii) *At the time of the breach there was a serious and obvious risk of death"* and *"(iv) It was reasonably foreseeable at the time of the breach of duty, that the breach gave rise to a serious and obvious risk of death"*. As the Lord Chief Justice observed in *Broughton,* these two elements will not need separate consideration in many cases but plainly the "serious and obvious risk of death" test is now a constant requirement of a proper direction. As a matter of archaeology, it is clear to see how it came to be omitted from the Coroner's directions to the jury in the present case. He based himself on earlier versions of the guidance published by the Chief Coroner for England and Wales in 2013 and 2016, which referred to "*risk of death*", apparently unaware that the guidance had been updated in 2021 to take account of more recent authorities. I have set out that later guidance in paragraph 5 above. In his judgment in the present case, the Chief Justice considered it to be "self-evident" that the Coroner had failed to direct the jury in relation to elements (iii) and (iv). However, he concluded that:

> *"…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".*

He based this on a factual matrix, which he described in these terms:

> *"the deaths… 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 (navigation or otherwise); in which objects were thrown by the occupants of the RHIB to obstruct or impede the (RGPV) in which the RHIB made evasive manoeuvres crossing the path of (RGPV) 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".*

He also considered that the misdirection was "*very materially mitigated*" by the Coroner's direction on the issue of "grossness", wherein the

Coroner had directed the jury that they had to be satisfied on the balance of probabilities, 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".*

Of course, the Chief Justice was reaching these conclusions in circumstances where he had already rejected the officers' case on the scope of the duty of care and the alleged breaches. If, as I have found, the Coroner had misdirected the jury on these prior issues, that has consequences in relation to the materiality of the self-evident misdirection on the "*serious and obvious risk of death"* because the test is whether it was reasonably foreseeable that the breach gave rise to such a risk.

16. In my judgment, it was incumbent on the Coroner to give the jury a clear direction as to how to consider whether any breach or breaches found by them gave rise to a serious and obvious risk of death. Moreover, the direction would have to focus on what was objectively reasonably foreseeable at the time of the breach of duty. As Mr Hodivala submitted, the test is objective and prospective. This is clearly illustrated in recent authorities. In *Honey Rose,* Sir Brian Leveson P said at paragraph 77:

> *"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… A reasonable risk of something serious is not the same as a recognisable risk of death… A mere possibility that an assessment might reveal something lift 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".*

Returning to the subject in *Kuddus* [2019] 1 WLR 5199, he said at paragraph 79:

> "*To put it more generally, 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. What is required is that the reasonable person would have foreseen an obvious and serious risk of death."*

On any view these are important aspects of the modern law of gross negligence manslaughter.

17. In this difficult area, it is essential that the various elements are analysed in a properly structured way. I consider that it was erroneous of the Chief Justice to neutralise the Coroner's misdirection by reference to his perception of "*the factual matrix*". It had the effect of assessing the seriousness and obviousness of the risk of death with the benefit of hindsight and was confined to one side of the argument rather than "all the circumstances of the case". The jury needed to be directed to focus on the acts and omissions which constituted the breach of the duty of care, so as to assess whether that negligence gave rise to a reasonably foreseeable serious and obvious risk of death. A less structured analysis created a danger that a risk that had eventuated might be mischaracterised without more as one that was serious and obvious as a matter of reasonable foreseeability. A properly directed jury considering these matters would have needed to consider, for example, whether there was such a reasonably foreseeable serious and obvious risk of death when the chase began, or as it developed, or only when the RHIB was caused to perform its final evasive manoeuvre which was likened to a "*hand break turn*". I am not intending to second-guess what a properly directed jury would find following an evaluation of all the evidence. We have not heard that evidence. The point is that, in my judgment, there were plainly difficult issues in relation to the "*serious and obvious risk of death*" which required resolution by the jury, but in relation to which they received no proper direction. For these reasons I respectfully

disagree with the Chief Justice's view that the self-evident misdirection was immaterial.

Conclusion

18. It follows from what I have said that, in my judgment, the Coroner's directions to the jury were deeply flawed in the respects identified in the three grounds of appeal. It is the submission on behalf of both Interested Parties that, notwithstanding any shortcomings in the directions given to the jury, their verdicts ought to be allowed to stand. Reference is made to a number of authorities including *R v Inner London South Coroner ex parte Douglas – Williams* [1999]1 ALL ER 344 in which Lord Woolf MR said at page 354:

> *"it is important not only to consider the misdirections individually but also cumulatively and ask whether they mean in the interest of justice the findings of this inquest should be quashed. I have no doubt that they should not. I say that for three reasons. First because they would not in my judgment affect the verdict to which the jury came. Secondly because it is most unlikely that a fresh inquest, which after this period of time would inevitably be less satisfactory than the present inquest, would come to any other verdict. And thirdly, because the present inquest was performed in an exemplary manner, the important purpose of investigating the facts and little more could be achieved by subjecting all concerned to the considerable expense and stress of a further inquest".*

19. It is clear to me that, given the misdirections I have identified, the present case is in a very different category to *Douglas – Williams*, and *R (Application of Francis and five others) v HM Coroner* [2010-2012] Gib LR 71, in which it was applied in this jurisdiction. Here the misdirections were, in my view, fundamental and egregious and I feel unable to say that it is most likely that a properly directed jury would reach the same verdicts. They might or they might not. The interests of justice require that the current verdicts be set aside on grounds of misdirection and that a fresh inquest should consider the evidence. There was a modest cross-appeal but, in the circumstances, it does not need to be addressed.

SIR NIGEL DAVIS, JA.

20. I agree with the reasoning and conclusion of Sir Maurice Kay P. I add some short observations of my own, primarily because of the evident importance of the case to all concerned.

21. The law is clear that the scope of the duty of care and the issue of breach of that duty require, in a context such as the present, consideration of all the circumstances. That is a particularly important aspect, moreover, when unlawful killing on the basis of gross negligence manslaughter is, as here, one potential verdict left to the jury. Yet the directions in the present case not only failed to make that fundamental point clear to the jury but also failed to marshal the evidence so as to identify the relevant circumstances which the jury would need to evaluate and weigh for the purpose of considering the verdicts left to them. To the contrary, the Coroner`s directions in effect simply set out (some) aspects of the evidence without any further guidance on this topic. The fact that in the case of *R (on the application of Francis)* it was adjudged that, notwithstanding the evident deficiencies, the directions to the jury in that case overall were sufficient to pass muster does not in any way compel a conclusion that the directions to the jury passed muster in the present case.

22. In my view, that factor of itself would require that the verdicts be quashed. But if more were needed it is to be found particularly in the regrettable failure to give a direction as to the requirement of a foreseeable serious and obvious risk of death: an essential legal element for gross negligence manslaughter. With all respect to the Chief Justice, I do not think it can be said that this failure by the Coroner to give such a direction was not material. To the contrary, the evidence of the Officers could not be wholly discounted; nor was it at all a given that even if there were a serious risk of a collision then such a collision might foreseeably take the horrific and fatal form that it actually did take.

23. We were much pressed in argument with the fact that the collision unquestionably took place in Spanish waters; and it was asserted to us that the Officers simply must have known that at the time. However, the Officers had denied that in evidence; and it would have been a matter for the jury whether to accept those denials. The point was, however, never clearly identified for decision in the Coroner`s directions. The Chief Justice took the view that, irrespective of whether or not the Officers proceeded in the honest belief that they were engaging the RHIB in BGTW, they were not acting in the execution of their duty as police officers: just because they were in point of fact in Spanish waters where they had neither jurisdiction nor powers of arrest. Consequently, as he held, "*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*": paragraphs 22 and 23 of the judgment.

24. With respect, that cannot be right. The Officers were on any view not acting as "ordinary citizens". They were, albeit in Spanish waters, acting as police officers in pursuit of a suspect RHIB intent on not being apprehended. Of course, in so acting they were still subject to the requirement to act reasonably in all the circumstances. One such circumstance would be whether or not they knew they were in Spanish waters and whether or not they knew that they could not lawfully apprehend the RHIB and those in it; but that would be for the jury to evaluate as part of their overall consideration of all the circumstances in assessing whether there was a breach of the duty of care owed. But those matters were never left to the jury.

25. Counsel for the respondents much pressed before us the interests of justice and the need for finality and closure in this tragic case. I do understand that. But an inquest of this sort has serious potential ramifications for all concerned. Since the directions to the jury were in material respects neither properly marshalled and balanced nor legally accurate justice requires, in my view, that there be a fresh inquest. Accordingly, I also would allow the appeal and dismiss the cross-appeal.

SIR ADRIAN FULFORD, JA.

26. I agree with both judgments.