



Neutral Citation Number: [2024] EWHC 2032 (Admin)

Case No: AC-2023-MAN-000410

**IN THE HIGH COURT OF JUSTICE**  
**KING'S BENCH DIVISION**  
**ADMINISTRATIVE COURT**  
**SITTING IN MANCHESTER**

Wednesday, 21<sup>st</sup> August 2024

**Before:**  
**FORDHAM J**

<b>Between:</b>	
<b>THE KING (on the application of HILLARY SMITH)</b>	<b><u>Claimant</u></b>
<b>- and -</b>	
<b>DIRECTOR OF PUBLIC PROSECUTIONS</b>	<b><u>Defendant</u></b>
<b>- and -</b>	
<b>(1) CHIEF CONSTABLE OF GREATER MANCHESTER POLICE</b>	<b><u>Interested</u></b>
<b>(2) AMECHI OMEJE</b>	<b><u>Parties</u></b>

**Jodie Blackstock** (instructed by Broudie Jackson Canter) for the **Claimant**  
**John McGuinness KC** (instructed by CPS) for the **Defendant**  
The **Interested Parties** did not appear and were not represented

Hearing dates: 17.7.24 & 18.7.24  
Written submissions: 19.7.24 & 22.7.24  
Draft judgment: 2.8.24

**Approved Judgment**

FORDHAM J

Remote hand down. This judgment was handed down remotely at 10am on 21st August 2024 by circulation to the parties or their representatives by email and by release to The National Archives.

## **FORDHAM J:**

### **Introduction**

1. This is a case about a decision by the CPS (Crown Prosecution Service) not to prosecute a licensed door supervisor for gross negligence manslaughter. The Claimant is the mother of Gavin Brown, who was aged 29 when he died on 20 April 2019 at Salford Royal Hospital. Mr Brown died of hypoxic/ ischaemic brain damage, having suffered a cardiac arrest in the context of physical restraint on 12 April 2019 outside The Melville pub in Stretford, Manchester. This is how the family’s solicitors described the circumstances of Mr Brown’s death when on 31 December 2022 they wrote to the CPS to request a review of an earlier decision not to bring a prosecution (SIA is the Security Industry Authority):

*On 12 April 2019, Gavin was restrained outside The Melville Pub in a Mixed Martial Arts (MMA)-style “choke hold” by a member of the public (referred to by the CPS as “Customer 1”) for over six minutes, which restricted his ability to breathe. He entered a cardiac arrest and died eight days later in hospital after suffering irreversible hypoxic ischaemic brain injury. An SIA-licensed door supervisor (“the Door Supervisor”) – who had received training on the risks of neck restraint and the need to monitor and respond to the condition of the person being restrained – failed to intervene.*

2. On 6 December 2021, a jury at a coroner’s Inquest returned a conclusion of “unlawful killing”. Inquest juries apply the civil standard of proof (the balance of probabilities), since R (Maughan) v Oxfordshire Senior Coroner [2020] UKSC 46 [2021] AC 454. By a decision letter dated 1 October 2022, a CPS Specialist Prosecutor (Gavin Hotchkiss) decided there was insufficient evidence to bring a prosecution, maintaining his pre-Inquest decision (25.9.20). The family’s request (31.12.22) was made under the VRR (Victim’s Right to Review) scheme. By a decision letter dated 23 May 2023, addressed to Mr Brown’s sister, another CPS Specialist Prosecutor (Paul Chamberlain) determined the review, deciding that there was insufficient evidence to bring a prosecution. That is “the Impugned Decision” in these judicial review proceedings. Mr Chamberlain is “the Decision-Maker”. A solicitors’ Letter Before Claim (8.8.23) identified why the Impugned Decision was said not to be lawful in public law terms. In responses (10.8.23 and 17.8.23), the Unit Head of the Special Crime Division at the CPS (Simon Ringrose) explained that, having considered the representations together with advice from King’s Counsel, it had been concluded that the Impugned Decision involved no error of law or public law unreasonableness.
3. The Claimant is supported in these judicial review proceedings by other members of the family. Family members attended the Inquest hearings and the two-day hearing in the High Court. I granted permission for judicial review on the papers (7.2.24), satisfied that the claim was arguable and warranted consideration at a substantive hearing. The materials include a compilation of CCTV and Body Worn Video, which I viewed ahead of the hearing and was played in open court. I am grateful to everyone associated with this case for their assistance. I am conscious that what was written and read for the hearing, and said at the hearing, and what follows in this judgment, will seem detached and analytical. We are dealing with the circumstances in which a young man died.

### **The Record of Inquest**

4. The Record of Inquest is a formal document in a mandatory prescribed form, recording the conclusions of the inquest (Maughan at §13). It contains the information, which the

Inquest jury provided in the discharge of their responsibilities, having received directions from the Coroner (Andrew Bridgman). This is what it records:

*1. Name of Deceased (if known). Gavin Jay BROWN.*

*2. Medical cause of death. [a] Hypoxic/Ischaemic brain damage. [b] Cardiac arrest in the context of physical restraint.*

*3. How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death. On the 12th April 2019, at approximately 20:21hrs, Gavin Jay Brown attended the Melville Pub. He was involved in an altercation, which resulted in him being held in a neck restraint for a minimum of 6 minutes and 19 seconds, by a male customer. During this time no welfare checks were made. This restraint led to irreversible hypoxic ischaemic brain injury, leading to Gavin's death at Salford Royal Hospital, on 20th April 2019 at 11:30 am.*

*4. Conclusion of the Coroner as to the death. Unlawful killing.*

5. The Court was provided with the Coroner's written directions to the jury, and the "route to decision" documents which the Coroner provided to assist the jury in light of those directions. Neither Counsel has criticised their contents. They were delivered at the public hearing of the Inquest. The jury was told by the Coroner that "you must accept those directions and follow them". The directions were clear. The jury was "specifically precluded, when answering the four questions, from making any determinations of criminal liability on the part of a named person or civil liability". The Coroner was leaving to the Inquest jury "unlawful act manslaughter" in respect of the actions of Customer 1 ("the male customer" who held Mr Brown in the "neck restraint"); and "gross negligence manslaughter" in respect of the actions of the Door Supervisor (in circumstances where "no welfare checks were made"). Given that there were two possible routes to unlawful killing, the Record of Inquest needed to reflect which, if any, they found. An addendum (wording was suggested) should be added into section 4 of the Record of Inquest if they had found one and not the other. But no addendum should be added into section 4 of the Record if the jury found "unlawful killing" by both of the two routes. Those were the directions.
6. The Inquest jury included no addendum in section 4. Ms Blackstock and Mr McGuinness KC agree that the jury are to be understood as communicating conclusions of both "unlawful act manslaughter" (Customer 1) and "gross negligence manslaughter" (the Door Supervisor). That would have been understood by anyone who attended the public hearings of the Inquest, in light of the Coroner's directions. The focus of these judicial review proceedings is on the Door Supervisor and his possible prosecution. The request for the review (31.12.22) and the Impugned Decision (23.5.23) addressed the position of Customer 1 (and two others: Customers 2 and 3). But the decision which is challenged, as identified in a Letter Before Claim (8.8.23) and the Grounds for Judicial Review (22.8.23), is the decision not to prosecute the Door Supervisor for the offence of gross negligence manslaughter.

#### Names and Anonymity

7. Customer 1 (Stefan O'Donnell) is named in the judicial review documents, including in police interview, witness statement evidence, expert evidence and notes of oral evidence at the Inquest. The Door Supervisor (Amechi Omeje) is named throughout the judicial review documents, was included as an Interested Party, and was served with the judicial

review proceedings. No application was made to anonymise any person as being necessary to secure the proper administration of justice and/or protect the interests of any person (CPR 39.2(4)).

8. In the judicial review court's judgment in R (Canham) v DPP [2021] EWHC 3361 (Admin), "three individual suspects" were "known as A, B and C" (§1). That was a case where the inquest was yet to take place (§51). I raised with Counsel the question whether names should be withheld in this judgment. I received helpful post-hearing written submissions. Mr McGuinness KC invited me not to identify the Door Supervisor or Customer 1, not because of any suggested prejudice to any possible future trial, but by reference to the general reasonable expectation of privacy of a person investigated but not charged (ZXC v Bloomberg LP [2022] UKSC 5 [2022] 2 AC 1158) and, in the Door Supervisor's case, the prospect of further investigation if the claim for judicial review succeeded before me or on appeal. I have given careful consideration to the position of the two individuals. But I agree with Ms Blackstock, that the necessity test for anonymity is not met, including by reference to the reasonable expectation of privacy. I am satisfied that no further enquiry or step is needed. No individual was named in the Record of Inquest and the Coroner directed the Inquest jury that no-one should be named. But Customer 1 and the Door Supervisor were both named during the Inquest, in public hearings; they each gave evidence at the public hearings of the Inquest; they were each named in the Coroner's directions and routes to decision, all of which were ventilated in public hearings at the Inquest. These judicial review proceedings arise out of the Inquest and involve direct consideration of the Inquest materials. I will continue to use shorthand descriptors: "Customer 1"; "the Door Supervisor"; "the Other Doorman" (for Alain Kanga, another licensed door supervisor at the pub) and "the Decision-Maker" (for Paul Chamberlain).

#### A Summary of the Evidence

9. In the Impugned Decision, the Decision-Maker said that the facts in this case were largely not in dispute, and it was the application of the law to those facts which was crucial in determining whether there is a realistic prospect of a conviction for any offence. He said he had reviewed all of the evidence considered by the original CPS reviewing lawyer, and had considered the evidence given at the Inquest, the reports of Dr Soar, and the evidence of an expert regarding the regulation of the security industry (Tony Holyland). Without attempting to set out the evidence in full, the Decision-Maker provided this summary of the evidence, as relevant to the issues raised in the case:

*On 12 April 2019, Gavin Brown attended the Head Bar with a friend at approximately 4.30pm. They had five or six pints of lager before leaving in a taxi after 8pm. Mr Brown asked the taxi driver to stop at a convenience store en route to their destination, and acquired a pair of rubber gloves and a black bin bag or liner. Once back in the taxi, he instructed the driver to stop in the vicinity of the Melville public house. The taxi driver states that Mr Brown seemed angry and told his friend to stay there and that he would 'sort this out'. There is evidence that Mr Brown was barred from the Melville. He then left the taxi and when he had not returned after five or six minutes, his friend also exited the vehicle in order to find him.*

*One of the doormen at the Melville [ie. the Other Doorman] was confronted by Mr Brown shortly after he left the taxi. He squared up to the doorman in a boxing stance and is described as having a mask on his face and a hood up. The doorman at first thought it was some kind of joke but was then punched twice. The doorman took them both to the floor by Mr Brown's legs and states he was gouged in the eye. He was screaming with pain. A female customer saw the initial confrontation and heard the doorman screaming. She mistakenly thought he had been hit in the*

*face with acid and went into the pub to get water. She was heard by a member of staff to say ‘He’s had acid thrown in his face’. Another witness says he heard a female customer shout ‘Water we need water. Acid attack. It’s all kicking off out there. His eyes. His eyes’. It seems that a further mistaken belief was aired that the doorman had been stabbed.*

*Various customers and staff went to the scene outside, which is described by two witnesses as chaotic. One customer states that Mr Brown was struggling and thrashing with two men restraining him, and that he felt the two men would be attacked if they let him free. Another customer outside saw the initial altercation and heard a scream she describes as ‘awful’ and unlike anything she had heard before. The witness saw people come out of the pub and one man, presumably Customer 1, put Mr Brown into a choke hold, telling him when he tried to move that ‘you’re not going fucking anywhere’. The witness states that there was no struggle once Mr Brown had been restrained. It is clear from the witness statements that once restrained, there was no further struggle from Mr Brown, who is described as not moving and not saying anything. One of the witnesses was told by two females that a doorman had been stabbed and had acid thrown in his face. The landlord told this witness to stay outside with Mr Brown ‘in case he kicks off’. The DJ at the pub was told that someone ‘had acid in his face’. He describes the scene as somewhat ‘chaotic’. He could see no movement from those involved in the restraint. One of the barmen was under the impression that there had been a fight resulting in someone having acid thrown in their face. He saw a doorman sat to one side with blood dripping from his eye. Some customers were shouting ‘you’re not going anywhere’. This witness wrongly informed police there had been an acid attack and a stabbing.*

*The actions of the suspects can be summarised as follows: Customer 1 had Mr Brown in what is described as a choke hold. The Door Supervisor is initially described as holding Mr Brown by his chest, although when police arrive he can be seen to be crouched by the Mr Brown’s feet on the body-worn video. There is little or no reliable evidence as to the physical involvement of Customer 2 and Customer 3, although the former admits to assisting in the restraint by putting his foot on Mr Brown’s ankle. The body-worn footage shows that as the police arrived, Customer 2 appears to be standing over Mr Brown with his foot on his legs.*

*The police arrived after Mr Brown had been held for over six minutes. The bodyworn video of the first two officers on the scene was recording. One officer could see that Mr Brown was being held in a ‘rear naked choke’, and that he had a bin bag around his lower face in the fashion of a snood. He instructed Customer 1 to release his hold and then arrested and handcuffed Mr Brown. When he was turned over and appeared to be unresponsive, the officer checked for a pulse and first aid was commenced. The second officer assisted in the arrest and it is only approximately one minute after their arrival that the officers raise concerns about the welfare of Mr Brown.*

*A statement was provided to the Coroner by an official from the Security Industry Association [Mr Holyland]. He describes the licensing regime for door supervisors. From 1 June 2010, physical intervention training was mandated in order to obtain a licence. The training was not required for existing licence holders but by 2016 it became part of the process for licence renewal applications. Those who did not receive training could no longer act as licensed door supervisors but could still work as licensed security guards. The Door Supervisor in this case would have received training when his licence was renewed in 2017. The training covered the risks of positional asphyxia, and the need to monitor the condition of a subject of physical intervention. The witness states that holding a subject on the ground is not regarded as safe practice and that force needs to be de-escalated at the earliest opportunity. Neck restraint should be avoided. Unnecessary use of force by others should be challenged. The course material that would have been used for the Door Supervisor’s training was provided in evidence.*

### A Summary of the Medical Evidence

10. The Impugned Decision has a section in which the Decision-Maker summarised the medical evidence. He did so as follows:

*A Home Office pathologist [Dr Charles Wilson] concluded that the cause of death was hypoxic/ischaemic brain damage, due to an out of hospital cardiac arrest in the context of physical restraint. He states that it is possible that Mr Brown's nose and mouth were obstructed by the plastic bag. It is equally possible that he may have suffered a cardio-respiratory arrest as a consequence of neck compression. These two asphyxia mechanisms are not mutually exclusive; Mr Brown may have been rendered hypoxic by a combination of neck compression and external obstruction of his airway by the plastic bag. Unconsciousness through neck compression can take place within 10 seconds and if not relieved, a risk of irreversible brain damage can arise within two or three minutes. A person who has been physically resisting restraint can become unconscious and suffer hypoxic brain damage more quickly than a person who is calm and not struggling.*

*A second doctor [Dr Jasmeet Soar] was instructed on behalf of the Coroner. His conclusion was that on the balance of probabilities, the significant contributing factor to the death was compression of the neck whilst being restrained in a choke hold. He states that the contribution of the bin liner is uncertain, but the harmful effects of the neck compression alone were sufficient to cause unconsciousness, cardiac arrest, a severe brain injury and death. This doctor states that neck compression can lead to unconsciousness within 8-18 seconds, and breathing can stop after one to two minutes. Cardiac arrest occurs between three and eleven minutes after breathing stops. At the inquest this second doctor stated that in his view the role of the bin liner was either limited or made no contribution to the outcome. At the request of the police, this doctor further expressed his opinion to the criminal standard of proof. He concluded that 'it is beyond reasonable doubt that compression of his neck whilst being restrained in a choke hold was a significant (i.e. more than trivial) contributing factor to the death of Gavin Brown'. The original pathologist was given the opportunity to comment further in light of the doctor's opinion but declined to do so, saying there was no new evidence upon which to change his view.*

Ms Blackstock and Mr McGuinness KC agree that the "bin liner" ("plastic bag") was and is irrelevant, given Dr Soar's view of its role.

#### A Summary of what the Door Supervisor's Said

11. The Impugned Decision includes this summary by the Decision-Maker of the accounts given by the Door Supervisor in two police interviews, and in his written and oral evidence at the Inquest:

*The Door Supervisor stated in interview that he came out of the pub at a point where three people were involved. Mr Brown had his hand around the other doorman's neck and was himself being restrained by the neck (presumably by Customer 1). The Door Supervisor knelt down and grabbed Mr Brown's elbow. He states that he did not have to apply much pressure and that Mr Brown did not try to lash out. He heard voices stating that the other doorman had been stabbed in the eye or had acid poured on him. He was concerned about his colleague's safety and was concerned that Mr Brown would lash out. He thought if he let go of Mr Brown he might get up and start fighting. He felt resistance from Mr Brown's arm but held him firmly.*

*In a second interview he stated that when he went outside, he heard the other doorman screaming 'My eyes. Help'. There were people screaming that the doorman had been stabbed and that there had been an acid attack. He stated that he felt the need to continue the restraint until police arrived and that Mr Brown was being reasonably held. He did not make any welfare checks and focussed on watching the crowd.*

*At the inquest the Door Supervisor gave evidence that it took a couple of minutes to extricate the doorman from Mr Brown. He says there were a lot of screaming people around him, and one of Mr Brown's friends was shouting to let him go. He informed the friend that he could not do so because of the damage to his colleague's eye and that he had to hold Mr Brown until police arrived. The Door Supervisor stated that there was a lot of resistance from Mr Brown when they removed his hand from the doorman and he continued to feel resistance until police arrived. Other people were in hysterics and screaming, he had an injured colleague and was concentrating on the attacked rather than the attacker. He states that he was focused on*

*preventing Mr Brown getting inside the pub because they had no idea what his intentions were or whether he was carrying a weapon. He felt that everyone was under threat.*

“Welfare Check” and “Change in the Restraint”

12. In the Record of Inquest (§4 above) the Inquest jury record that, during the period in which Mr Brown was held in the neck restraint by Customer 1, no “welfare checks” were made. The Coroner used the phrase “welfare check” in the directions and routes to decision, making clear to them: that this meant “failure to check on Gavin’s welfare (with a change in the restraint)”; in the context of any duty of care to “ensure Gavin’s well-being while he was being restrained”. The Decision-Maker spoke (§35 below) of the prosecution proving that the “failure to conduct a welfare check” was “a breach of his duty of care, referring both to the importance of steps “to monitor the life signs of a subject held in a high-risk position” and to the “dangers of rear-choke, or strangle holds”. Mr McGuinness KC accepts that a “change in the restraint” would be a necessary part of a “welfare check”, even if its purpose were solely to monitor life signs. Ms Blackstock agrees and says that the duty of care included effecting a change in the restraint (see §31i below).

The “Extrication” of the Other Doorman

13. As has been seen, the Decision-Maker refers to the Door Supervisor’s Inquest evidence about how long it took “to extricate the doorman from Mr Brown”. There are other references in the Impugned Decision to it taking some time “to extricate the doorman” (§44[h] below); and the point at which “the other doorman [was] safely removed from the situation” (§48 below). The family’s Letter Before Claim describes the position “once Mr Kamga was free” (§33v below). I will call this the “Extrication”. As recorded on the timeline produced by Greater Manchester Police, and from the CCTV footage itself, the Other Doorman is seen being led away from the incident at 20:27:43. In fact, his feet can be seen standing to the side of the incident at 20:27:40. Mr McGuinness KC accepts that, on the evidence, the Extrication had taken place by 20:27:40. To put that into context, the CCTV footage shows the Other Doorman doing a “take down” of Mr Brown at 20:26:10; and Customer 1 is in view, standing in the pub doorway, until 20:26:40, and Customer 1’s actions of holding Mr Brown in a neck restraint must have been after 20:26:40.

The Six Elements of Gross Negligence Manslaughter

14. It is common ground that the Decision-Maker correctly identified the six necessary Elements of the crime of gross negligence manslaughter, in this passage in the Impugned Decision (numbers in square brackets are mine), derived from R v Broughton [2020] EWCA Crim 1093 [2021] 1 WLR 543 at §5:

*Gross negligence manslaughter is a common law offence requiring proof of the following elements: [i] The defendant owed an existing duty of care to the victim. [ii] The defendant negligently breached that duty of care. [iii] That breach of duty of care gave rise to an obvious and serious risk of death. [iv] It was also reasonably foreseeable that the breach of that duty gave rise to a serious and obvious risk of death. [v] The breach of that duty caused the death of the victim. [vi] 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.*

15. The key cases to which I was referred as to gross negligence manslaughter were: R v Adomako [1995] 1 AC 171 (30.6.94); R v Misra [2004] EWCA Crim 2375 [2005] 1 Cr

App R 21 (8.10.04); R v Sellu [2016] EWCA Crim 1716 (15.11.16); R v Rose [2017] EWCA Crim 1168 [2018] QB 328 (31.7.17); R v Winterton [2018] EWCA Crim 2435 [2019] 2 Cr App R 12 (6.11.18); R v Kuddus [2019] EWCA Crim 837 [2019] 1 WLR 5199 (16.5.19); Broughton (18.8.20); R v Wood Treatment Ltd [2021] EWCA Crim 618 (28.4.21); and Canham (10.12.21).

### The Issues

16. There are three agreed issues. They relate to Elements [iv], [v] and [vi], the prospects of proving each of which was assessed by the Decision-Maker to fall below the threshold required to satisfy the Evidential Stage of the Full Code Test (§17 below).

*Issue 1: Reasonable Foreseeability. Was the decision of the prosecutor that a properly directed jury would more likely than not conclude that it was not reasonably foreseeable given the Interested Party's knowledge and position that at the time of his breach of duty of care, his failure to act would result in a serious and obvious risk to Mr Brown's life an error of law, or so unreasonable that no objective prosecutor could have reached it?*

*Issue 2: Causation. Was the decision of the prosecutor that a properly directed jury would more likely than not conclude that the breach of the Interested Party's duty of care did not cause the death of Mr Brown an error of law, or so unreasonable that no objective prosecutor could have reached it?*

*Issue 3: Truly Exceptionally Bad. Was the decision of the prosecutor that a properly directed jury would more likely than not conclude that the Interested Party's negligence was not so gross as to convict him of manslaughter, so unreasonable that no objective prosecutor could have reached it?*

### The Evidential Stage of the Full Code Test

17. By s.10 of the Prosecution of Offences Act 1985, Parliament required the DPP to issue a Code giving guidance on general principles to be applied by Crown Prosecutors in deciding whether to prosecute. The Full Code Test has two stages: the Evidential Stage; and the Public Interest Stage (Code §4.3). In relation to the Evidential Stage, the Code says this (§§4.6 and 4.7):

*4.6 Prosecutors must be satisfied that there is sufficient evidence to provide a realistic prospect of conviction against each suspect on each charge. They must consider what the defence case may be, and how it is likely to affect the prospects of conviction. A case which does not pass the evidential stage must not proceed, no matter how serious or sensitive it may be.*

*4.7 The finding that there is a realistic prospect of conviction is based on the prosecutor's objective assessment of the evidence, including the impact of any defence and any other information that the suspect has put forward or on which they might rely. It means that an objective, impartial and reasonable jury or bench of magistrates or judge hearing a case alone, properly directed and acting in accordance with the law, is more likely than not to convict the defendant of the charge alleged. This is a different test from the one that the criminal courts themselves must apply. A court may only convict if it is sure that the defendant is guilty.*

### A Preliminary Point

18. Under a heading "Application of the Code for Crown Prosecutors", the Decision-Maker explained in the Impugned Decision why "I cannot weigh the Inquest verdict in my assessment of the evidential test as strongly as I am sure you would hope". In the course of that explanation, the Decision-Maker said this (underlining of text in quotations connotes emphasis added):



*Another reason that the [Inquest] verdict of itself cannot be taken as a foundation for criminal proceedings is that the decision of the jury was made on the balance of probabilities. In legal terms, this equates to a finding that your brother's death more likely than not, or probably, constituted an unlawful killing. This is a significantly lower standard of proof than that required in criminal proceedings. In determining whether there is a realistic prospect of conviction, I have to consider whether a jury could be sure on the evidence of a defendant's guilt.*

19. Ms Blackstock says there is a material error of law here. She argues, in essence as I saw it, as follows. It is true that a jury at a criminal trial would apply a standard higher than the balance of probabilities, being sure on the evidence of guilt. But the question at the Evidential Stage of the Full Code Test is a deliberately lower threshold. It is asking whether a prosecution should be brought, and so whether a case will be put before a jury at all, for the jury to decide. It involves the lower standard of the balance of probabilities. That means the Evidential Stage is satisfied where the prosecutor considers that there is a sufficiency of evidence as to guilt, applying the lower standard. That means asking a question about guilt on the balance of probabilities. It does not involve considering whether a jury could be sure, on the criminal standard. That is the point being made in the last two sentences of Code §4.7 (§17 above):

*This is a different test from the one that the criminal courts themselves must apply. A court may only convict if it is sure that the defendant is guilty.*

Otherwise, those two sentences make no sense and would not have been included. All of which is supported by a passage in Manning (at §22), describing (and endorsing) an explanatory memorandum which had emphasised that the Evidential Test required a “realistic prospect of conviction” and had said:

*There had to be an objective assessment of that evidence. The Crown Prosecution Service should not look for the same standard of proof that a jury or bench of magistrates would need to find before it could convict, which would set too high a standard and tend to usurp the role of the court. The test based on “more likely than not” meant just that.*

The material error of law made by the Decision-Maker in the Impugned Decision was to “look for the same standard of proof that a jury or bench of magistrates would need to find before it could convict”. That is the argument.

20. As Mr McGuinness KC pointed out, this criticism of the Impugned Decision was advanced for the first time orally by Ms Blackstock at the hearing (she accepted that it had not been part of any “frontal” attack); it had not featured in the Letter Before Claim, the Judicial Review Grounds or the Skeleton Argument. However, recognising that it was a pure point of law which could and should be dealt with, Mr McGuinness KC did not take his stand on procedural rigour and ask that it be shut out. He asked me to deal with it. Procedural rigour matters of course. But in the circumstances of the present case, given the considerations of justice and the public interest, I record that I found in this stance a creditable recognition by a public authority of the room which exists in judicial review for appropriate procedural flexibility.
21. I have been unable to accept Ms Blackstock’s submissions on this preliminary point. The answer lies in recognising that there are two distinct moving parts. One moving part is about what would need to happen, when a criminal court is deciding whether to convict, if a prosecution is brought. As to that, the crown court jury will always need to apply the criminal standard. That is a key point which distinguishes a crown court jury from an inquest jury. So, what always needs to happen is that the crown court jury need to be sure

of the defendant's guilt. This is what is reflected clearly in the idea (Code §4.7) of what happens when:

*an objective, impartial and reasonable jury or bench of magistrates or judge hearing a case alone, properly directed and acting in accordance with the law ... convict the defendant of the charge alleged.*

22. The other and distinct moving part is about predicting whether a criminal court would convict, if a prosecution is brought. There are, various different ways in which that predictive question could in principle be framed and approached, for the purpose of deciding whether to bring a prosecution. It could be a very low predictive threshold: is there assessed to be a "more than minimal" prospect of a conviction? It could be a very high predictive threshold: is there assessed to be an "inevitable" prospect of a conviction? It could involve being sure (beyond reasonable doubt) of conviction. That would be to use the criminal standard, for the predictive threshold. Or it could involve assessing it as likely (on a balance of probabilities). That would be to use the civil standard, for the predictive threshold. The predictive phrase "realistic prospect" of conviction (Code §4.6), when it is used in the particular context of the Code, means "more likely than not". Is it objectively assessed as more likely than not that a criminal court would convict? That is the use of the civil standard, which is different from the criminal standard, as the predictive threshold.
23. The two moving parts then come together. The predictive question is whether it is objectively assessed as more likely than not that a criminal court – doing what criminal courts do – would convict. Thinking about 'doing what criminal courts do' makes it a real, and not a false, scenario which is being predicted. And 'doing what criminal courts do' brings in what would need to happen when a criminal court is deciding whether to convict, if a prosecution is brought. That is, to apply the criminal standard. And so, the two moving parts combine in this way (Code §4.7):

*an objective, impartial and reasonable jury or bench of magistrates or judge hearing a case alone, properly directed and acting in accordance with the law, is more likely than not to convict the defendant of the charge alleged.*

As to which this (ie. the predictive threshold):

*... is a different test from the one that the criminal courts themselves must apply. A court may only convict if it is sure that the defendant is guilty.*

That is referring to the predictive threshold; not what the jury would be doing. Otherwise, there would have been an immediate contradiction of "jury ... properly directed and acting in accordance with the law".

24. So, the question is "whether a properly directed jury is more likely than not to convict" (Canham §26). It is whether a jury is likely, on the balance of probabilities, to convict. It is not whether a jury, applying the balance of probabilities, would convict. There is no inconsistency with Manning. In that case, Lord Bingham (at §19) had quoted an explanation which spoke about a "reasonable prospect" of satisfying a jury "beyond reasonable doubt". The idea about why (at §22) the Crown prosecutor needed to avoid the criminal standard, which would be set too high and tend to usurp the role of the court, was addressing the predictive threshold. The Code itself referred to the prospect of conviction by a criminal court "properly directed in accordance with the law" (§21). This

was all about prosecuting a defendant “whom a jury would be likely to convict” (§23). “Likely” is the prosecutor’s predictive threshold. But “convict” is by the jury being sure to the criminal standard.

25. Ms Blackstock submits that, even if this is so, the Decision-Maker went wrong in law in failing to identify and answer the right question. I am unable to accept that further submission. The Decision-Maker is a senior prosecutor. The Impugned Decision begins by referring to the tests set out in the Code. It refers to “the fundamental rule that no case can be charged unless the evidence is sufficient to provide a realistic prospect of conviction”. It refers – within the subsequent substantive reasoning – to “the evidential test in the Code”. When he said – correctly – that he had to “consider whether a jury could be sure” he was explaining why he could not “weigh” the Inquest jury’s decision – which he explained has been “made on the balance of probabilities” – as “strongly” as the family would hope. He concluded that there was “insufficient evidence to provide a realistic prospect of a conviction” and that the “evidential test in the Code for Crown Prosecutors is not satisfied”.

### The Nature and Intensity of Review

26. The key cases to which I was referred in relation to judicial review of a prosecutorial decision were: R v DPP, ex p Manning [2001] QB 330 (17.5.00); R (Monica) v DPP [2018] EWHC 3508 (Admin) (14.12.18); R (Campaign Against Antisemitism) v DPP [2019] EWHC 9 (Admin) (9.1.19); Canham (10.12.21); and R (COL) v DPP [2022] EWHC 601 (Admin) (17.3.22). The case law makes clear that a decision made by a crown prosecutor in the application of the full code test is susceptible to judicial review on conventional grounds which include public law unreasonableness. The duty to act reasonably requires a reasonable outcome (within the range of reasonable outcomes). It also involves reasonableness in the decision-making process (including a reasonably sufficient enquiry). And reasonableness in the reasoning process (with no demonstrable flaw, such as a serious logical or methodological error): see eg. COL at §62.
27. In deciding whether any public authority decision-maker has acted unreasonably, the intensity of the applicable scrutiny is context-sensitive and the latitude for evaluative judgment depends on fact and context. There are really three key themes which overlap and underpin the latitude which the judicial review court must always afford to the primary decision-maker (Manning §23). The first is about the institutional primacy and independence of the CPS. The second is about the specialist expertise and experience which senior prosecutors, making and reviewing decisions, bring to bear as primary decision-makers. The third is about the nature of the questions being addressed which, in the context of the Evidential Stage, necessarily include evaluative and predictive exercises of judgment. In Canham Whipple J referred to a “single invariable approach” (§§48-49), rejecting a suggested modified test replacing public law unreasonableness in Article 2 cases (§47). In COL the Divisional Court left open a similar argument in an Article 4 case (§§35-37, 62), making reference to the variable standard of scrutiny, possible “fine tuning”, and “intensification”.
28. Ms Blackstock accepts that the threshold for unreasonableness intervention is high. She was content to proceed on the basis of a single and heightened standard of reasonableness review. But she points to the features of this case, involving a decision not to prosecute, in a case involving a death, where an inquest has returned a decision of unlawful killing, involving the decision-maker’s application of an objective standard in the application of

legal principles and the evaluation of the materials, all of which are before the judicial review court. For his part, Mr McGuinness KC supports the single invariable approach, which he says is seen throughout the case-law.

29. This is how I see the position in law:

- i) Reasonableness is the single and invariably-applicable standard of review (Canham §§48-49). It is the conventional standard of substantive review.
- ii) The delineated scope of the judicial function matters. Judges can and do, of course, evaluate questions which involve the application of the criminal law. So far as the Elements of gross negligence manslaughter are concerned, a crown court judge may have to decide whether there is a case to answer (evidence taken at its highest on which a jury could convict). The Court of Appeal Criminal Division may have to consider whether to reverse a terminating ruling of no case to answer (see eg. Wood Treatment §3) or quash a conviction (see eg. Rose §94). There is always a delineated scope of the judicial function.
- iii) The delineated scope of the judicial function, when dealing with a judicial review of the substance of a prosecutorial decision, is the conventional standard of reasonableness, absent a material error of law. Reasonableness must start, and continue, with the recognition that it is the independent specialist prosecutor who is the primary decision-maker entrusted with the application of the Code Test. There is no appeal to the High Court; still less on evaluative or predictive merits.
- iv) Within the single and invariably-applicable standard of reasonableness review, there may be room for contextual factors to make a difference. One of the virtues of the conventional standard lies in its contextual application. The idea that the court needs to stand back “the more so” since the VRR scheme was introduced (Canham §40) is one example. The idea of special restraint in finding unreasonableness “where a CPS review decision is exceptionally detailed [and] thorough” (Monica §46(1)) is another example. The Court is applying the single governing standard of public law reasonableness, consistently with the wide latitude afforded (for principled reasons) to evaluative and predictive judgments of specialist independent prosecutorial decision-makers. But the questions are really these. (1) May the judicial review court find, in the presence of features (compared with their absence), a need to have more from the reasons provided to justify the decision as reasonable? (2) May the judicial review court find from those features (compared with their absence), a need to do more by way of careful scrutiny? (3) Should the judicial review court be transparent about what it finds? My answer is “yes” to all three of these questions. And so, I will turn to answer the third of them.
- v) In the present case, I have found – in the presence (compared with the absence) of the combined features of a decision not to prosecute, in conjunction with a loss of life, after an unlawful killing verdict of a jury at an inquest – a need to have more from the reasons provided to justify the decision as reasonable; and a need to do more by way of careful scrutiny. Notwithstanding that, I am still looking for a reasonable decision and reasoning process; I am still recognising an extensive, principled width of the latitude for evaluative and predictive judgments of the primary decision-maker. Indeed, what I have said does not mean, in the present context and the present case, that the latitude for the primary decision-maker’s

evaluative and predictive judgment has narrowed at all. It is the same latitude which the decision-maker has, in assessing what is correct, acting reasonably. The differences lie in what the court needs, and what the court does, in its quest of being satisfied that the decision-maker's assessment (of what it considered correct) was a reasonable one.

### The Case Analysis

30. In her written and oral submissions, Ms Blackstock delineated the path by which – on the evidence – the jury would be made sure of the six Elements of gross negligence manslaughter, and which she says the Impugned Decision unlawfully or unreasonably fails to address. In his submissions, Mr McGuinness KC characterises this as a “case theory”. I will call it the “Case Analysis”. At the heart of it is the moment of Extrication of the Other Doorman (§13 above).
31. This is the Case Analysis:
- i) The Door Supervisor was aware that Customer 1 was holding Mr Brown in a chokehold. The Door Supervisor had been trained as to the high danger to life from a person being held in a chokehold. The chokehold was not hidden from the Door Supervisor. That means it was not something that would have been ascertained from the discharge of the very duty of care that was breached (see Rose). This means that the Extrication is the latest time of the onset of a truly exceptionally bad breach of the duty of care, by failing to ensure a change in the restraint.
  - ii) The Extrication is also the earliest time at which Mr Brown lost consciousness. On the evidence (§50 below), Mr Brown had a grip on the face of the Other Doorman up to the point of Extrication, and Dr Soar's evidence explained the sort of action (and perceived action) which can continue after a loss of consciousness. The idea that the Other Doorman was unable to get away from an already-unconscious Mr Brown is unrealistic and unsupported by evidence. That means that every realistic alternative, to Mr Brown being conscious up to the point of Extrication is excluded.
  - iii) The earliest time at which Mr Brown's injuries were irreversible was one minute after the loss of consciousness. That is Dr Soar's evidence. That means there was a minimum time window of 60 seconds from the Extrication, in which the discharge by the Door Supervisor of the duty of care owed to Mr Brown – by ensuring a change in the restraint – would have saved Mr Brown's life.
  - iv) True, that the truly exceptionally bad breach of the duty of care could have arisen earlier than the Extrication; but the point is that it could have arisen no later than that. True, that Mr Brown's loss of consciousness could have occurred later than the Extrication; but the point is that it could have occurred no earlier than that. True, that the irreversibility of the injuries could have occurred later than 60 seconds from the Extrication; but the point is that it could have occurred no earlier than that. That means that every realistic alternative is excluded, to there having been a minimum time window of 60 seconds in which all six Elements of gross negligence manslaughter are satisfied.
32. Mr McGuinness KC has two key points. First, that this Case Analysis was not supplied until Ms Blackstock's oral submissions at the hearing of the judicial review proceedings.

That means, in particular, that it was not put to Dr Soar at the Inquest. Secondly, that the claim for judicial review has to be addressed on the basis of the “evidence” that was before the Decision-Maker. That includes the evidence arising from the Inquest. There is force in both points. Ms Blackstock’s response is that it is the “evidence” from the Inquest that is being relied on. She also says that the Case Analysis should be no surprise to anyone in these proceedings, and has been the substance of the Claimant’s position since the Letter Before Claim (8.8.23).

33. I agree with both Counsel that the Decision-Maker had to focus on the evidence that arose from the Inquest; as must I. But I think Ms Blackstock is right that the Case Analysis matches the position in the Letter Before Claim. All of the following is extracted from the Letter Before Claim, showing the position being taken on behalf of the Family regarding the satisfaction of the six Elements of gross negligence manslaughter. It closely fits with the Case Analysis. So, it is not new. And the CPS’s Letter of Response said the Letter Before Claim had been considered and the Impugned Decision was being maintained:

*(i) Mr Omeje owed a duty of care to Mr Brown. (ii) Mr Omeje objectively breached that duty of care by failing to stop the chokehold restraint in accordance with his training and/or check Mr Brown was breathing. (iii) There was objectively a serious and obvious risk to Mr Brown’s life...*

*(iv) Reasonable foreseeability at the time that a breach of the duty of care would result in a serious and obvious risk to Mr Brown’s life... There was nothing hidden about the risk. Mr Brown was lying on the ground in front of Mr Omeje in the chokehold. Mr Omeje had received training that this hold, especially conducted on the ground, was a risk to life because it could cause positional asphyxia. He accepted in evidence that he knew this and he received training as to the risks. His knowledge was therefore distinct to the members of the public present. It should therefore have been clear and unambiguous to him that Mr Brown’s life was at risk if he did not stop the chokehold, or at a minimum, monitor his breathing in that position...*

*(v) The breach of the duty caused or made a significant (i.e. more than minimal) contribution to the death of the victim... Dr Soar’s evidence as to fatality is that although a person can become unconscious within a matter of seconds, the impact of a lack of oxygen takes longer to have an effect on the brain... His statement and evidence to the inquest was clear that if the chokehold had stopped within one to two minutes of him becoming unconscious, Mr Brown would have been able to regain his breath and would have survived. From the CCTV footage and evidence given, that window of time was clearly available if Mr Omeje had followed his training – stopped the chokehold once Mr Kamga was free; taken him from the prone position on the floor to a seated position; and checked his breathing. All these were reasonable steps to have taken at that point. There was no necessity to continue the chokehold after Mr Kamga was released. Mr Kamga was free of the hold and removed away from Mr Brown. There were two members of the public there assisting with the restraint who could have continued to do so in a safer hold should Mr Omeje have appropriately directed them to do so, and taken the lead in an appropriate restraint himself...*

*(vi) 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... [T]he context is that Mr Brown is being held on the ground in a hold known to Mr Omeje to be a risk of death, with no necessity for the hold to be applied. Mr Omeje says that he was concerned about his colleague and was focussed on getting him help. But Mr Kamga was getting that help and the police and ambulance had already been called. Mr Omeje accepts that he remained kneeling by Mr Brown’s side, with his hands on Mr Brown’s arm. The eye witness evidence is that there was no further movement after this point from Mr Brown. A minute spent remaining still is a long time. Mr Omeje had plenty of opportunity to avoid Mr Brown’s death by stopping the hold and conducting a welfare check.*

Issue 1: Reasonable Foreseeability

34. The agreed issue is:

*Issue 1: Reasonable Foreseeability. Was the decision of the prosecutor that a properly directed jury would more likely than not conclude that it was not reasonably foreseeable given the Interested Party's knowledge and position that at the time of his breach of duty of care, his failure to act would result in a serious and obvious risk to Mr Brown's life an error of law, or so unreasonable that no objective prosecutor could have reached it?*

This issue concerns Element [iv]. The legal merits of this issue came into very clear focus through the submissions at the oral hearing. The key point is about proving the Door Supervisor's awareness of the chokehold, at the first step in the Case Analysis (§31i above).

35. I start with the Decision-Maker's reasoning. The Impugned Decision had recorded this position regarding Elements [i] and [ii]:

*I am quite satisfied that the Door Supervisor owed a legal duty of care to your brother. He was acting in the course of his employment at the Melville public house when he became involved in the incident with Mr Brown. The next element of the offence is proof of a negligent breach of that duty of care. In my view the prosecution would have to prove that a failure to conduct a welfare check on Mr Brown constituted a breach of his duty of care. The training material provided by the industry professional makes it clear that it is important to monitor the life signs of a subject held in a high-risk position. The dangers of rear-choke, or strangle holds are also highlighted in the training. I am therefore satisfied that a breach of the Door Supervisor's duty of care to Mr Brown could be proved.*

Then this:

*However, the difficulties in this case really begin after this point, and I am afraid that the prospects of proving the remainder of the elements of gross negligence manslaughter fall below the threshold required to satisfy the evidential test in the Code for Crown Prosecutors.*

36. There then follows this passage which deals with Element [iv] the reasonable foreseeability (of Element [iii] the obvious and serious risk of death arising from the breach of the duty of care) (the numbered paragraphs in square brackets are mine):

*[iv] [a] Firstly, it is necessary to prove that it was reasonably foreseeable that the breach of duty of care gave rise to a serious and obvious risk of death. The law is clear that a risk of something serious does not equate to a risk of death, and is not sufficient for the offence of gross negligence manslaughter. The serious and obvious risk of death also has to be reasonably foreseeable on an objective basis. I have to consider what the likely defence would be if the offence was charged, and the effect that any defence would have on the prospects of conviction. [b] A defence lawyer in this case would in my view invite the jury to question why, if a serious and obvious risk of death existed, not one person present at the scene appeared to be aware of it? There is no evidence of anyone alerting Customer 1 or the Door Supervisor to the fact that Mr Brown's life was seriously and obviously in danger, including the police who attended. As the most highly trained of any party involved whilst the restraint was ongoing, the police did not immediately tell Customer 1 to break off the restraint for fear of a serious and obvious risk of death to your brother. They in fact instructed Customer 1 to let go so they could arrest him, which they proceeded to do and then handcuffed him before realising the seriousness of his condition. [c] The question of what constitutes a serious and obvious risk of death has been recently considered by the courts in the case of Rose (Honey Maria) [2017] EWCA Crim 1168. The 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. The court concluded that the question of serious and obvious risk must be*

*assessed with respect to knowledge at the time of the breach of duty. It was therefore not appropriate to take into account what the defendant would have known but for his breach of duty. [d] In the context of the present case, the Door Supervisor cannot therefore be held liable for something he would have discovered had he not negligently failed to conduct a welfare check on Mr Brown. For these reasons, it is not possible in my view to sufficiently prove an obvious and serious risk of death on the evidence in this case.*

It is common ground that paragraphs [iv][a] and [c] are legally correct statements of the law; and that the crux of the Decision-Maker's reasoning is at [iv][d].

37. Here is the essence, as I saw it, of the submissions made by Mr McGuinness KC in defence of the reasonableness of the Decision-Maker's adverse conclusion on Element [iv]. The problem to which the Decision-Maker was referring was about the prospects of making a jury sure that the Door Supervisor knew that Customer 1 was holding Mr Brown by a chokehold. This explains the Decision-Maker's reference to "knowledge at the time of the breach of duty" and a risk only "apparent on further investigation" (at [iv][c]). If the chokehold was not to the "knowledge" of the Door Supervisor, it would instead only have "become apparent on further investigation", and only when the Door Supervisor discharged the duty to conduct a welfare check. That is what the approach in Rose excludes. It is what the Decision-Maker meant. It was a reasonable position to take in relation to the evidence in the case, applying the Evidential Stage as a predictive evaluative judgment. Particularly in light of various passages in the Door Supervisor's police interviews and inquest evidence, in which he describes the position as he experienced it. Those were the submissions.
38. I have been unable to accept these submissions. On this part of the case, I accept the submissions of Ms Blackstock. There are three problems. The first problem is that nowhere in the Impugned Decision is it said or explained by the Decision-Maker that there is a problem, on the evidence, of a jury being sure that the Door Supervisor was aware of the chokehold. The Decision-Maker does not identify the "something" that the Door Supervisor "would have discovered" (at [iv][d]). This could have been a reference to the fact that Mr Brown was unconscious; or the fact that he had stopped breathing; or the fact that there was a bin bag. The second problem is that, elsewhere in the Impugned Decision there is a summary of evidence which does not record a lack of knowledge – but rather a knowledge – of the chokehold. As has been seen (§11 above) the summary within the Impugned Decision refers to the account that the Door Supervisor had given in his police interview (13.4.19). The Decision-Maker records:

*The Door Supervisor stated in interview that he came out of the pub at a point where three people were involved. Mr Brown had his hand around the other doorman's neck and was himself being restrained by the neck (presumably by Customer 1). The Door Supervisor knelt down and grabbed Mr Brown's elbow...*

The third problem is that this is what is said in the record of interview to which reference is being made:

*... I just made my way outside as soon as possible. When I got outside I saw three bodies on the ground and all had their back towards the door the entrance. So when I walked round I could see it was Gavin could see my colleague on the door Alain Kamga he was also on the floor. So I saw that the third person was holding Gavin in a restraining order by his neck or something like that but he's holding him back to restrain him and Alain was also on the ground as well with Gavin's hand around his head. So I grabbed Gavin's hand ...*



The reference here – in an account given to the police the day after the incident – is about what “I saw” and refers specifically to “by his neck”. Later in the same interview there was this (DC is the detective constable):

*DC So you’ve come to the front you see Alain and you see Stefan. Where is Stefan in this equation.*

*OMEJE Stefan is holding Gavin around his neck restraining him in a restraining hold...*

39. I was not able to see how various other passages to which Mr McGuinness KC invited my attention, involving later descriptions by the Door Supervisor of his state of mind during the incident, can supply an answer in light of these three problems with this part of the Impugned Decision. I record that, at the Inquest, the Door Supervisor (AO in the note of evidence) disavowed “neck” and now said “chest”. The Coroner (HMC) and family’s barrister (FP) picked up the inconsistency with the police interview. These extracts are from the family’s solicitors’ note of the oral evidence at the Inquest on which both parties have relied (SO is Stefan O’Donnell; G is Gavin):

*HMC So when you arrived outside Stefan was already there holding Gavin.*

*AO He was holding him in a restraining order.*

*HMC Where were his arms?*

*AO To be honest it was around his chest.*

*HMC The first thing you said to police was “restraining order by his neck or something like that”. We heard from SO that when he came outside you were already there.*

*AO No.*

...

*FP You knew that neck restraint was extremely dangerous.*

*AO In that instant it was dangerous.*

*FP Especially if done by someone without any training.*

*SO I can’t answer that as I don’t know Mr O’Donnell’s training.*

*HMC The question refers to anybody without training.*

*AO Um yes. I was grateful for whoever was able to help. Wasn’t a question of who had training. I was grateful that Mr O’Donnell helped.*

*FP You knew that neck restraint was dangerous and you knew SO was holding G in a neck restraint – you must have known.*

*AO He was holding him around his chest. At the time I was more focussed on the injured person.*

*FP The evidence you gave to the police was Stefan was holding Gavin in a restraint after his neck. p.2 of the interview*

*AO At the time I didn’t really focus on that, more focused on the screams I could hear, help them out of the predicament.*

40. The reasoning in the Impugned Decision does not explain that it had been assessed as unlikely, nor why in light of the evidence from the police interview it had been assessed as unlikely, that the prosecution would be able to make a crown court jury sure that the Door Supervisor was already aware that Customer 1 was holding Mr Brown in a chokehold, so that this was not within his knowledge at the time of the breach of duty, and would not only have been known from conducting a welfare check. I have concluded, as did the judicial review court in COL (at §62), that “the explanations offered simply do not justify the conclusions” and the “reasons provided are not capable of substantiating the conclusions”. The reasons do not justify the decision as reasonable, in light of the evidence and what was said earlier in the Impugned Decision. I would arrive at that conclusion based upon the application of standard public law standards and principles

(COL §63) and independently of any nuanced approach to intensity of review. Whether this means the Impugned Decision ought to be quashed and the matter remitted for reconsideration afresh depends on the analysis in relation to the remaining issues.

41. I record that, on this part of the case, Mr McGuinness KC did not place freestanding reliance on the points made by the Decision-Maker in the Impugned Decision at [iv][b]. In those circumstances, it is sufficient for me to make two points. First, in Rose (at §84) the Court explained that:

*The test of reasonable foreseeability simply requires the notional objective exercise of putting a reasonably prudent professional in the shoes of the person whose conduct is under scrutiny and asking whether, at the moment of breach of the duty on which the prosecution rely, that person ought reasonably (ie. objectively) to have foreseen an obvious and serious risk of death.*

Secondly, as Ms Blackstock submitted, the unaddressed problem with the emphasis on the position of “anyone ... including the police who attended” is that the bystanders were not “reasonably prudent professionals” trained in the dangers of neck restraint; and the arriving police were not “in the shoes” of the Door Supervisor.

42. The key point on Issue 1 is not complicated. It is straightforward. The Door Supervisor accepted in a police interview, the day after the incident, that he could see that Customer 1 was holding Mr Brown by the neck. The Impugned Decision records that awareness. It goes on to make an adverse assessment on reasonable foreseeability, without mentioning that awareness, and without mentioning any supposed problem in proving it. In judicial review proceedings, a supposed problem in proving that awareness is put forward to justify the reasonableness of that adverse assessment. It is unidentified, and unexplained, in the Impugned Decision itself.

#### Issue 2: Causation

43. The second agreed issue is this:

*Issue 2: Causation. Was the decision of the prosecutor that a properly directed jury would more likely than not conclude that the breach of the Interested Party’s duty of care did not cause the death of Mr Brown an error of law, or so unreasonable that no objective prosecutor could have reached it?*

This issue concerns Element [v]. Again, the legal merits came into very clear focus through the making and testing of oral submissions at the substantive hearing. The key point is about proving the earliest time at which Mr Brown lost consciousness, at the second step in the Case Analysis (§31ii above).

44. Here is the Decision-Maker’s reasoning (with paragraph numbering added):

*[v] [a] Even were that not the case, the next element to be proved is also fraught with difficulty. [b] The prosecution would have to prove that the breach of duty in not conducting a welfare check caused the death of Mr Brown. [c] Unlike many cases of gross negligence manslaughter, a prosecution of the Door Supervisor would be based on a failure to do something on his part. Many cases of gross negligence manslaughter involve a defendant who has done an obviously negligent and dangerous act. [d] Where that is not the case, such as here, the prosecution must prove that had the defendant not neglected to do what he should, the deceased would have survived. The case of Broughton [2020] EWCA 1093 put this another way, namely that in order to be sure that the gross negligence caused the death, the prosecution must exclude realistic or plausible possibilities that the deceased would anyway have died. [e] This is extremely hard to prove in the circumstances of this case. [f] There is no evidence upon which to conclude with any*

*certainty when Mr Brown's condition became irreversibly fatal. [g] It is also impossible to identify a specific point at which the Door Supervisor should have made a welfare check, and if that point in the timeline were to have been after Mr Brown was already fatally injured, the Door Supervisor's negligence would not be responsible in law for the death. [h] What can be said with some certainty is that the duty on the Door Supervisor to conduct a welfare check would not have arisen as soon as the choke hold was applied by Customer 1. At that stage the other injured doorman was still entangled with Mr Brown and to the mind of the Door Supervisor, in danger of further potentially serious assault. A jury is almost bound to conclude that it would have taken some time to extricate the doorman and properly restrain Mr Brown before any duty on the Door Supervisor to check Mr Brown's welfare could have arisen. [i] Even if the Door Supervisor had made a check at the first available opportunity he reasonably had to do so, we cannot disprove the possibility that fatal injury to your brother had already occurred by that point. [j] I have to conclude therefore that there is insufficient evidence to satisfy the legal test for causation in gross negligence manslaughter against the Door Supervisor.*

45. Ms Blackstock accepts that [v][d] correctly states the law. She says the points at [v][f] to [h] fail to provide a reasonable basis for the conclusion at [i]. If they stood alone and in isolation, I would agree. This is why:
- i) The Decision-Maker's point at [v][f] is that there is no evidence upon which to conclude with any certainty when Mr Brown's condition became irreversibly fatal. But what matters is whether there is evidence upon which to conclude with certainty when was the earliest that Mr Brown's condition became irreversibly fatal.
  - ii) The Decision-Maker's first point at [v][g] is that it is equally impossible to identify a specific point at which the Door Supervisor should have made a welfare check. But what matters is not one specific point of breach, but a point which was the latest at which breach started. The Decision-Maker has accepted Elements [i] and [ii]. What must be possible is to identify a point which was the latest at which the Door Supervisor should have made a welfare check.
  - iii) The Decision-Maker's second point at [v][g] is this. If the point in the timeline at which the Door Supervisor should have made a welfare check were after Mr Brown was already fatally injured, the Door Supervisor's negligence would not be responsible in law for the death. That is right. But not so if the earliest that Mr Brown's condition became irreversibly fatal came after the latest at which the Door Supervisor should have made a welfare check.
  - iv) The Decision-Maker's point at [v][h] is this. The duty to conduct a welfare check would not have arisen as soon as the chokehold was applied by Customer 1, and it would have taken some time for the Extrication of the Other Doorman and to properly restrain Mr Brown before any such duty could have arisen ([h]). That is also quite right. But it is all consistent with a duty which did, at the latest, arise after the Other Doorman was in fact Extricated. Which is precisely the moment at which the 60 second window identified in the Case Analysis.
46. Mr McGuinness KC submits as follows. This is an evaluative judgment by a specialist prosecutor, having directed himself correctly in law. What is key is the ultimate conclusion (at [v][i]): even if the Door Supervisor had made a check at the first available opportunity he reasonably had to do so, the prosecution could not disprove the possibility that fatal injury to Mr Brown had already occurred by that point. The Decision-Maker was reasonably recognising that it would be extremely hard to prove in the circumstances

of the case ([v][e]). The reasons ([v][f] to [h]) contained no logical flaw or gap. The Decision-Maker was not required to “dissect the timeline” and took the reasonable and informed evaluative view that dissecting the timeline was unlikely to lead the jury to a safe and sure conclusion. Read fairly, and as a whole, what the Impugned Decision does – reasonably in public law terms – is to recognise as a realistic and plausible possibility that Mr Brown had already lost consciousness during the period before the Extrication (ie. 20:27:40 at the latest).

47. In my judgment, that last point is where the focus must be. The question is whether, read fairly and as a whole, the Decision-Maker was reasonably recognising that Mr Brown could on the evidence already have lost consciousness during the period before the Extrication. That is the second step in the Case Analysis. I am satisfied that this is what the Decision-Maker was concluding, and that it cannot be characterised as unreasonable. I will explain why I have reached that conclusion.
48. The Impugned Decision does need to be read fairly and as a whole. What the Decision-Maker was saying about the Door Supervisor and Element [v] followed on from an earlier discussion about a possible prosecution of Customer 1. In that earlier discussion, the Decision-Maker was addressing causation in the context of Customer 1 acting in self-defence, and spoke of “the initial stages of the incident” and “the initial restraint”. Read fairly, that is clearly a reference to the period up until the Extrication. This then led to consideration of causation. Here is what the Impugned Decision says:

*I have no doubt in the] circumstances that a properly directed jury would find Customer 1’s use of force to protect the doorman or indeed others from harm to have been reasonable and therefore lawful in the initial stages of the incident... I anticipate that you might ... wonder whether there came a point where initially reasonable use of force became unreasonable and therefore unlawful after Mr Brown was effectively restrained and the other doorman safely removed from the situation. This raises complex issues of legal causation. The medical practitioners are at least agreed that unconsciousness due to neck compression can occur very quickly, within a matter of seconds, and that cardiac arrest and irreversible brain injury can follow soon thereafter. This time scale becomes even shorter where there has been physical exertion through struggle. In order to attribute criminal liability for the death of Mr Brown to Customer 1, the prosecution would have to prove that the fatal injury was sustained during a period of the restraint which we could assert was unlawful. You will already appreciate that I am of the view that the initial restraint will be deemed to have been lawful. How could the prosecution prove that the fatal injury did not occur during that period of lawful restraint? The medical evidence cannot provide a definitive answer on the issue, and a jury will be directed that any doubt must always as a matter of law be resolved in the favour of a defendant. I do not therefore believe that trying to dissect the timeline in this way could lead the jury to a safe and sure conclusion on legal causation.*

49. There is a clear conclusion here that the prosecution could not “prove that the fatal injury did not occur during that period of lawful restraint”. That was plainly the period up to Extrication, when “the other doorman [was] safely removed from the situation”. It was in the context of expert evidence that “unconsciousness due to neck compression can occur very quickly, within a matter of seconds”. The Decision-Maker – having specifically addressed the point – did not think the prosecution could prove that Mr Brown was still conscious at the moment of Extrication. There is therefore no gap in the reasoning. Reading the Impugned Decision fairly and as a whole, the Decision-Maker’s point at [f] was that there is no evidence upon which to conclude with any certainty when Mr Brown’s condition became irreversibly fatal, the prosecution being unable to prove that this was not in the period of initial restraint, prior to the Extrication. That answers the objection. It means there is not evidence upon which to conclude with certainty that

the Extrication was the earliest that Mr Brown lost consciousness and 60 seconds after the Extrication was not the earliest that his condition became irreversibly fatal. This is no more than joining the dots between the Decision-Maker's reasoning in relation to Customer 1 and in relation to the Door Supervisor.

50. That means Ms Blackstock has to demonstrate that this was an unreasonable view of the evidence. It was unreasonable to think that the prosecution would not be able to prove that Mr Brown must have been conscious up to the point of the Extrication. On that, Ms Blackstock has two points. First, she can point to Dr Soar's evidence about what happens on loss of consciousness:

*when an individual is restrained there can be an initial voluntary struggle as part of a survival instinct. As the brain blood flow and oxygen levels decrease and consciousness is lost the body will continue to make involuntary movements including strong efforts to breath[e] (agonal breaths), and body spasms and stiffening (seizures) for a short period (e.g. up to a minute) – these ongoing movements after loss of consciousness are often mistaken as an ongoing active resistance to the restraint.*

Secondly, she can point to the Door Supervisor's accounts, summarised by the Decision-Maker, as including that "there was a lot of resistance from Mr Brown when they removed his hand from the doorman" (§11 above). The Decision-Maker elsewhere refers to Customer 2's evidence: "they were trying to get the Other Doorman out of Mr Brown's grip". The Door Supervisor told the police: "I pulled Gavin's arm out and held it. Then at that time that point Alain was able to get free then and go and get seen to"; and "Gavin ... had hold of Alain" so that when the Door Supervisor "took hold of Gavin's hand that he had Alain with. Alain got away". These are points on the factual and evidential merits.

51. But the question is about making a jury sure. Ms Blackstock's skeleton argument contains the submission that "it is ... the case that Mr Brown was not unconscious during the time that he continued to hold onto Mr Kamga with a tight grip and give a lot of resistance to his removal." The pleaded grounds for judicial review record that: "according to Mr Omeje's evidence, he was pulling Mr Brown's grip off Mr Kamga's head and taking hold of his arm. He described Mr Brown's grip as strong". However, on that basis, the pleaded contention was as follows:

*... It is ... therefore reasonable to assume that Mr Brown was not unconscious during the time that he continued to hold onto Mr Kamga with a tight grip.*

In the same vein, it is not unfair to record that in Ms Blackstock's oral submissions, she began with an analysis which put forward an earliest loss of consciousness of 20:27:10. She was entitled to withdraw that contention and I do not hold her to it. But it does rather illustrate the problem about proof, clarity and room for doubt. It is at this point, moreover, that it has to be recalled that it was not put to Dr Soar at the Inquest that the description of the witnesses who gave evidence was inconsistent with Mr Brown having already lost consciousness. The point is that, rightly, the Decision-Maker was thinking about what the prosecution could prove; and whether "we can disprove the possibility" of the fatal injury having occurred by the time of the first available opportunity which the Door Supervisor reasonably had. That was what was being evaluated. On this issue, the explanations and reasons do justify and substantiate the conclusions. The reasons justify the decision as reasonable, in light of the evidence and what was said earlier in the Impugned Decision. Moreover, the Decision-Maker was very clear that causation was addressed on the premise that he was wrong about Element [iv] (reasonable

foreseeability). It follows that the claim for judicial review cannot succeed. The Decision-Maker's evaluative conclusion, that the Evidential Stage test is not satisfied for a necessary Element of the crime of gross negligence manslaughter, means there is no basis for overturning the Impugned Decision or remitting the matter for reconsideration afresh.

### Issue 3: Truly Exceptionally Bad

52. The agreed issue is:

*Issue 3: Truly Exceptionally Bad. Was the decision of the prosecutor that a properly directed jury would more likely than not conclude that the Interested Party's negligence was not so gross as to convict him of manslaughter, so unreasonable that no objective prosecutor could have reached it?*

This issue concerns Element [vi].

53. My attention was invited to Part 1 of the Crown Court Compendium (July 2024) which says this (p.19-26 at §2 and p.19-30 at §14):

*[I]t must, in the opinion of the jury, amount to gross negligence. The question, "supremely a jury question", is: "having regard to the risk of death involved, was the conduct of the defendant... so bad in all the circumstances as to amount in the jury's judgement to a criminal act or omission?" ...*

*... The courts have emphasised that to repeat the word "gross" is insufficient. The jury need to understand that they must be sure of a failure that was not just serious or very serious but "truly exceptionally bad". The offence does not require mens rea. There is no need to prove the defendant's state of mind and in particular their foresight of the risk of harm or death. However, the courts have held that there may be cases in which the defendant's state of mind is "relevant to the jury's consideration when assessing the grossness and criminality of his conduct". This approach has been endorsed on a number of occasions, and it has been recognised that it may operate in the accused's favour.*

54. In understanding this Element, is it helpful to reflect on what else is necessary – but not sufficient – from Elements [i] to [v]. It comes to this. It is proved that the defendant owed an existing duty of care to the victim; that the defendant negligently breached that duty of care; that the breach by the defendant of that duty of care gave rise to an obvious and serious risk of death; that it was reasonably foreseeable that the breach of that duty gave rise to a serious and obvious risk of death; and that the breach by the defendant of that duty caused the victim's death. But this is not sufficient. The law has deliberately insisted on further Element [vi].

55. This was the Decision-Maker's reasoning:

*Even assuming for a moment that causation could be made out, the prosecution would still have to satisfy the final element of gross negligence manslaughter, namely that the breach was a gross breach. The threshold for such a finding by the jury has been set very high by the court in the case of Misra ... The court stated that the jury would have to find the defendant's actions so truly exceptionally bad in all the circumstances as to amount to a criminal act or omission. In the circumstances of this case, I am afraid that I consider the test for grossness to present another insurmountable hurdle for the prospects of a conviction for gross negligence manslaughter. The Door Supervisor's breach of duty, if proved, came in the context of what he would at the time have believed to have been a serious and potentially ongoing assault on a colleague by Mr Brown, resulting in a reasonable need to restrain and detain him until the arrival of the police. Particularly where the alleged breach is an omission, I do not believe that the circumstances of*

*this case would allow a properly directed jury to conclude that the Door Supervisor's conduct was truly exceptionally bad, and therefore grossly negligent.*

56. Ms Blackstock submits, in essence as I saw it, as follows. The Decision-Maker's analysis of Element [vi] is infected by errors in the approach taken in relation to the earlier Elements. Here, as with Element [iv] (issue 1), the Decision-Maker has failed to address the implications of the Door Supervisor being aware of the chokehold. Here, as with Element [v] (issue 2), the Decision-Maker has failed to identify the 60 second period – after the Extrication of the Other Doorman – during which the Door Supervisor failed to act, at which action would have saved Mr Brown's life. Here, as before, the Decision-Maker's approach does not answer the Case Analysis. The references to the Door Supervisor and what he believed "at the time", and to a serious and potentially ongoing assault on a colleague, are very clear references to the earlier part of the incident prior to the Extrication. The same is true of the points made orally by Mr McGuinness KC on this part of the case. He described a scenario which was not of the Door Supervisor's making, in which the Door Supervisor had not directly been involved, which involved an attack on a colleague in circumstances where people were shouting (it later turned out incorrectly) that there had been an acid attack or a stabbing; where the Door Supervisor intervened as part of his job, to protect a colleague. What all of this misses, is that the focus needs to be on the relevant point, at which the duty of care arose and was breached, when there was the serious and obvious risk to life which was reasonably foreseeable, namely after the Other Doorman had been released, and during the full one minute (60 seconds) after the Extrication. That was when Customer 1's chokehold continued. Those were the changed circumstances in which the duty was breached, and it is those changed circumstances which made the breach truly exceptionally bad. That is why points referable to the earlier circumstances can supply no answer. So far as the perceived reasonable need to restrain and detain Mr Brown until the arrival of the police is concerned, this too misses the point. The breach was not changing the position of the restraint. A trained Door Supervisor, aware of the danger to life of a chokehold, simply could not perceive a reasonable need to detain by the continuation of the chokehold without the welfare check entailing a change in position of the restraint. The decision on this Element is unreasonable as to outcome, and because of the clear deficiencies in the reasoning.
57. I have been unable to accept these submissions. Applying the Evidential Stage to Element [vi] was a judgment call. It required of the Decision-Maker, an independent senior prosecutor, a predictive evaluative judgment. It was undertaken in the express basis that all the other Elements could be proved, and the Decision-Maker was wrong as to Elements [iv] and [v]. This was a senior prosecutor assessing, with experience and practical realism, whether a jury in a criminal trial would be likely to find this Element proved so that they were sure. The Decision-Maker was well aware of the position after the Extrication, and expressly referred to circumstances "resulting in" a reasonable need to restrain "until the arrival of the police". The Decision-Maker was aware that the circumstances as they were in the period after the Extrication had not arisen in a vacuum. They were the immediate aftermath of what had just taken place. The Decision-Maker spoke of the "context". The function of evaluative prediction belongs to the Decision-Maker. As Mr McGuinness KC emphasises, this was not contact initiated by the Door Supervisor. To him, when he arrived, an aggressor had confronted his colleague and had caused an eye injury. The Extrication of the Other Doorman meant he had been led to safety. For Element [vi] to be arrived at, Customer 1's chokehold should have been broken, and it was a breach of the duty of care owed by the Door Supervisor that he did

not think and act to make sure that happened, at a time of reasonably foreseeable real and obvious risk to Mr Brown's life. That means there would have been a proven, serious and negligent default, with a real and obvious risk to life. An experienced independent prosecutor did not think, as an evaluative predictive judgment, that it was likely that a jury at a crown court trial would be sure that this met the high threshold of truly exceptionally bad.

58. In Canham, Whipple J said this (at §§67-68):

*[The decision-maker] needed to consider, in line with the Code for Crown Prosecutors, whether the jury were more likely than not to find that the breach or breaches, if established on the evidence, were indeed gross, as that term has been interpreted in case law and assuming a proper direction... It was for [him] to make that assessment. That assessment was in the end a matter of impression. It did not require lengthy analysis or explanation...*

This Court must recognise and respect the latitude to be afforded to the primary decision-maker, to whom the responsibility for the evaluative predictive judgment has been entrusted. Given that this is essentially a judgment call based on all the evidence and all the circumstances, and given the discipline described in the reasoned decision of assuming that the other Elements of gross negligence manslaughter are all provable, I am unable to find in the Impugned Decision any error of approach or legal inadequacy. This evaluative predictive conclusion was squarely within the responsibility and latitude afforded to the senior independent prosecutor who conducted the review. It follows that, even if I had decided issue 2 in the Claimant's favour, I would have dismissed the claim for judicial review. The Decision-Maker has lawfully decided that the Evidential Stage is not met in relation to Element [vi].

### Conclusion

59. I have explained that there were six Elements of gross negligence manslaughter and each needed to pass the Evidential Stage, in the evaluative assessment of the primary decision-maker. Although I have found in favour of the Claimant on issue 1 (Element [iii]) and would have remitted that matter for reconsideration, I have rejected the claims on issue 2 and in any event on issue 3 (Elements [v] and [vi]). I have found that the Decision-Maker has lawfully decided, as an evaluative assessment, that the Evidential Stage was not met in relation to two of the necessary Elements of gross negligence manslaughter. In those circumstances and for those reasons, I cannot accept the claim for judicial review and must dismiss it. Counsel were agreed, in light of the judgment circulated in draft, that the appropriate Order is as follows. (1) The Claimant's claim for judicial review is dismissed. (2) The Claimant shall pay the Defendant's costs on the standard basis, to be the subject of detailed assessment if not agreed, and not to be enforced save by order of the Court pursuant to s.26 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012. (3) There be detailed assessment of the Claimant's publicly funded costs.