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ROYAL COURT
(Samedi Division)

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17th July, 1997

Before: Sir Philip Bailhache, Bailiff, and Jurats Le Ruez and Potter.

In the matter of Heidi Elizabeth Angela Cassin, deceased.

Representation of Her Majesty's Attorney General, under Article 16 of the Inquests and Post Mortem Examinations (Jersey) Law 1995, seeking an Order quashing the finding of the Inquest, held on 16th December, 1993, and directing that a fresh inquest be held.

Mrs. S. Sharpe, Crown Advocate.
The Viscount did not appear and submitted himself *à la sagesse de la Cour.*

JUDGMENT

THE BAILIFF: This is a representation by the Attorney General pursuant to Article 16 of the Inquests and Post-Mortem Examinations (Jersey) Law 1995, to which we shall refer as the 1995 Law, seeking to quash the finding of an inquest held on 16th December, 1993, into the death of Heidi Elizabeth Angela Cassin, to whom we shall refer as "Heidi".

Heidi was born on 23rd March, 1966, and died in St. Saviour's Hospital on 11th December, 1993, aged 27. At the time of her death she was a patient detained under the provisions of Article 31 of the Mental Health (Jersey) Law 1969.

At the inquest, presided over by the Deputy Viscount and conducted with the assistance of a Jury, the following verdict was returned:

> *"That the body is that of Heidi Angela Elizabeth Cassin, aged 27 years and 8 months, native of St. Helier, Jersey, and that she died on Saturday, 11th December, 1993, at St. Saviour's Hospital where she was a patient: death being due to reflex cardiac arrest consequent to self-induced hanging a few minutes previously but that it has not been possible to conclude whether she then intended the result of her own act".*

Article 16 of the 1995 Law is in the following terms:

> *"(1) Where an inquest has been held and it is shown to the satisfaction of the Court, on an application made by, or on behalf of, the Attorney General that, by reason of fraud, irregularity of proceedings, the discovery of new facts or*

evidence, or otherwise, it is necessary or desirable in the interests of justice that another inquest should be held, the Court may quash the finding of the former inquest and order that another inquest should be held.

(2) On any such inquest, unless the Court otherwise directs, all evidence taken on the former inquest in respect of the death shall be deemed to have been taken on the new inquest.

(3) Except as otherwise provided by this Article, or by the order of the Court, any such inquest shall be held in the same manner as any other inquest".

The grounds for the request from Heidi's mother for the Attorney General to make this application were that there had been an irregularity of proceedings and that new facts or evidence had been discovered. Accordingly, her legal adviser urged the Attorney that it was necessary or desirable, in the interests of justice, that the finding of the Jury in December, 1993, be quashed and a fresh inquest ordered.

At the inquest in December, 1993 evidence was heard from Dr. David Spencer, Director of Pathology, who gave the cause of death as being a cardiac arrest due to hanging. Heidi had, apparently, secured a dressing-gown cord around her neck, but she had not asphyxiated. She had died very rapidly from the cardiac arrest caused by the pressure on a crucial part of her neck.

Further medical evidence was heard from Dr. Anushya Thillai, a Registrar in Psychiatry at St. Saviour's Hospital. Dr. Thillai gave evidence that Heidi had been under care since 1987 and had had numerous admissions into the hospital system for overdoses and other self-inflicted injuries. At the time of her death, she was being treated for problems relating to depression. However, Dr. Thillai did not think that at the material time Heidi was actively suicidal.

Finally, evidence was heard from a Police Officer, WPC Ellis, who was permitted to summarise part, but not all, of the evidence of certain members of staff at St. Saviour's Hospital, who had seen Heidi shortly before her death. WPC Ellis confirmed that, from the point of view of the Police, there was no suspicion of foul play.

Curiously, it appears from the transcript of proceedings that the members of staff in question, Staff Nurse Gary Reynolds, Staff Nurse Gerald Purvis, and Nursing Assistant Susan Le Brocq, were present but were not called upon to give evidence.

Having heard the three witnesses, to whose evidence we have referred, the Deputy Viscount summed up to the Jury and the verdict was later pronounced.

It is the failure of the Deputy Viscount to hear evidence from the three members of staff at St. Saviour's Hospital which gives rise to this representation.

Counsel for the Attorney General submits that there was an irregularity of proceedings within the meaning of Article 16 of the 1995

Law. We accept that submission. It is clearly important that the evidence of those persons who last saw a deceased person alive should, in general, be given. It must be rare that such evidence is not relevant to the proceedings.

Counsel goes on to submit that it is necessary or desirable, in the interests of justice, that another inquest should be held. This submission gives rise to different and more difficult considerations.

Mrs. Sharpe helpfully referred us to a number of authorities where the provisions of the Coroner's Act 1988 and earlier legislation have been interpreted by the English Courts. These authorities are helpful because the terms of the English legislation are almost identical to the terms of the 1995 Law.

However, we need first to say a little more about the evidence of the three members of staff at St. Saviour's Hospital, as it appears from their statements. Staff Nurse Purvis was on duty with Staff Nurse Reynolds and Nursing Assistant Le Brocq on 11th December, 1993, the day of Heidi's death. Staff Nurse Purvis had a discussion with Heidi, when giving her the prescribed medication, and said that she was concerned about going to the Adult Psychiatric Unit the following morning. Staff Nurse Purvis said that she did not appear angry and gave no impression to him of any tendency to inflict self-harm.

Heidi left the nurses' offices between 23.10 and 23.15 hours. Staff Nurse Purvis then heard a call from Nursing Assistant Le Brocq summoning help in the female bathroom area. When he entered that area, Staff Nurse Purvis saw Staff Nurse Reynolds holding the deceased, apparently to take the weight off a dressing-gown cord which Heidi had secured around her neck. Staff Nurse Purvis loosened the cord and Heidi was placed on the floor. Both nurses tried unsuccessfully to resuscitate her and summoned medical assistance. Staff Nurse Purvis stated that he did not think Heidi had intended to take her own life.

Staff Nurse Reynolds stated that he had begun work at 19.30 hours on 11th December, 1993. He had been in the dining area at 23.30 hours, when Nursing Assistant Le Brocq asked him to come quickly to the female bathroom area where she said that Heidi was hiding behind a curtain. He said that Nursing Assistant Le Brocq seemed frightened and upon pulling back the shower curtain, he saw Heidi with a dressing-gown cord tied around her neck and around the shower curtain rail. She was kneeling on a small table. Staff Nurse Reynolds immediately lifted Heidi, while Nursing Assistant Le Brocq summoned help. Staff Nurse Purvis eventually arrived. Staff Nurse Reynolds said that he found no pulse and commenced mouth to mouth resuscitation, combined with heart massage. Despite all his efforts, he obtained no response.

Nursing Assistant Le Brocq stated that she had also begun work at 19.30 hours on 11th December, 1993. She recalled going to the female toilet at about 23.30 hours and, on entering the room, saw Heidi's arm from behind the curtain. Heidi was apparently standing up. Nursing Assistant Le Brocq called out but obtained no response and then went to summon help from Staff Nurse Purvis. She then went to telephone the ambulance and the doctor on duty. She had seen Heidi shortly before her death and the demeanour of the deceased woman had given her no cause for concern.

Counsel for the Attorney General submits that if this evidence had been heard, it is possible that a different verdict might have been returned.

Mrs. Sharpe referred us to the case of In re Davis, deceased (1968) 1 QB 72 where it was sought to quash a verdict of suicide, returned in the case of a woman who had jumped from the second floor window of a hospital. The headnote of the report records the decision of the English Court of Appeal in the following terms:

> *"(1) that where the ground on which it was sought to quash a coroner's inquisition was an insufficiency of inquiry into the cause of the death, the court would quash the inquisition and order a fresh inquest only if it were probable that there would be a different verdict at the new inquest.*
>
> *(2) That suicide required an intention on the part of a person to kill himself, so that to justify a verdict of suicide it must be shown that he knew what he was doing and was aware of the probable consequences of his acts.*
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> *(3) That on a reconsideration of all the evidence, including that of the deceased's own doctor, it was unlikely that any coroner would probably find that the deceased did not know what she was doing at the time of her fall or did not appreciate the probable consequences, and, therefore, since a fresh inquest would probably not result in any different verdict, the application would be dismissed."*

The test as to the probability of a different verdict being returned was doubted In re Rapier, deceased (1988) 1 Q.B. 26. Woolf LJ referred to a note in Halsbury's Statutes of England, 4th ed., vol. 11 (1985), p.359. He continued:

> *"The note reads: "An inquisition will not be quashed unless it is shown that there would probably be a different verdict if a new inquest were held". In support of the note there is a reference to In re Davis, decd. [1968] 1 Q.B. 72 and Reg. v. Cardiff City Coroner, Ex parte Thomas [1970] 1 W.L.R. 1475.*
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> *If this is a correct statement of general principle, then that could be crucial to the outcome of this application because Mr. Simon cannot go so far as to submit that the new evidence which is now available makes it probable that a different verdict would be reached. I am bound to say that, before considering the authorities, my initial reaction was one of surprise in reading the note since it would seem to involve a much more restrictive approach than that which is contained in section 6 of the Act of 1887 and section 19 of the Act of 1926, both of which set out the critical statutory requirement as being that it should be necessary or desirable in the interests of justice that another inquest should be held.*
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> *Indeed, until pressed by the court, Mr. Sankey was not inclined to put the test as high as this. He opened his submissions by saying that the test is whether the new facts and evidence*

would support a different verdict. On this basis, it would be sufficient if it was possible there could be a different verdict. This appears to be a much more satisfactory approach because, in many cases, and I would include this case as an example, it will be quite impossible to say what will be the effect of the new evidence. The effect which it will have will only be known after the witnesses have given their evidence and have been questioned. They may then be believed or they may not be believed. However, whatever the outcome, it still may be in the interests of justice that their evidence should be explored in public before a jury".

We respectfully agree that to ask whether it is probable that a fresh inquest will produce a different verdict is to impose too high a threshold.

However, the crucial question is whether it is necessary or desirable in the interests of justice that a fresh inquest be held. The possibility of a different verdict being recorded is clearly a very important consideration, but it may be that the Court might consider it desirable for fresh evidence to be explored in public, even if it thinks it likely at the end of the day that the same verdict will be returned.

In our judgment the Court should not fetter its discretion by imposing tests which might not meet the justice of the individual case.

We therefore turn to consider whether, on the facts of this case, it is necessary or desirable to order a fresh inquest.

Mrs. Sharpe conceded that the possibility of a different verdict being recorded was not high. Indeed, she submitted that it was likely that another open verdict would be recorded. What purpose would then be served by the quashing of the 1993 verdict, on the ground of irregularity of proceedings, and ordering a fresh inquest? In our judgment the answer is none. There has been no questioning of the evidence of Dr. Spencer as to the cause of death. There has been no questioning of the evidence of the Police Officer that there was no suspicion of foul play. In addition, much time has passed since the original verdict and no satisfactory explanation has been given as to why it has taken so long to question the proceedings which took place in 1993. We were told that separate proceedings have very recently been instituted against the Hospital Authority by the heirs or executors arising out of Heidi's death, but we do not think that this is a material consideration for our purposes. We were informed that the Viscount had been appraised of this application by the Attorney General but was content to make no submissions and wished to rest on the wisdom of the Court.

Notwithstanding the failure of the Deputy Viscount to hear evidence from the nurses as to an area of relevant fact, we have reached the conclusion that it is neither necessary nor desirable in the interests of justice for a fresh inquest to take place at this late stage. The application of the Attorney General is accordingly dismissed. In doing so we wish to make it clear that we well understand the reasons why the Attorney General referred the matter to the Court. This is the first occasion upon which the Court has been asked to exercise its power under Article 16 of the 1995 Law. We hope that the observations set out above

will offer some guidance as to the approach which the Court proposes to adopt in exercising this statutory power.

Authorities.

Inquests and Post-Mortem Examinations (Jersey) Law 1995: Article 16.

Coroner's Act 1988: s.13.

Jervis on the Office and Duties of Coroners: pp.342-347.

R. -v- H.M. Attorney General *ex parte* Ferrante (8th February, 1995) Unreported Judgment of the Court of Appeal of England.

R. -v- Divine, *ex parte* Walton (1930) 2 K.B. 29.

In re Davis, deceased (1968) 1 Q.B. 72.

R. -v- Cardiff City Coroner, *ex parte* Thomas (1970) 1 W.L.R. 1475.

R. (Smith) -v- Coroner for the County of Antrim (1980) N.I. 123.

In re Rapier, deceased (1988) 1 Q.B. 26.

R. -v- West Sussex Coroner, *ex parte* Edwards (1991) J.P. 186.

In the matter of Catherine Lucy Clegg, deceased (1997) C.O.D. 166.

Mental Health (Jersey) Law 1969: Article 31.