Neutral Citation Number: [2019] EWCA Crim 837

Case No: 201804753 B1

IN THE COURT OF APPEAL (CRIMINAL DIVISION)
ON APPEAL FROM THE CROWN COURT AT MANCHESTER
Yip J
T20187098

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/05/2019

Before :

THE PRESIDENT OF THE QUEEN'S BENCH DIVISION
(SIR BRIAN LEVESON)
MR JUSTICE STUART-SMITH
and
MR JUSTICE JEREMY BAKER

- -

Between :

MOHAMMED ABDUL KUDDUS	**Appellant**
- and -	
THE QUEEN	**Respondent**

(Transcript of the Handed Down Judgment.
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Simon Myerson QC for Mohammed Abdul Kuddus
Peter Wright QC for the Crown

Hearing date : 12 March 2019

Judgment
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Sir Brian Leveson P :

1. At all material times, Mohammed Abdul Kuddus was the sole director (and, effectively, the owner) of a limited company, RS Takeaway Ltd ("the Company"), which operated a takeaway business in Oswaldtwistle from premises known as Royal Spice where he also worked as a tandoori chef. Harun Rashid had previously owned the business before selling it to Mr Kuddus: he also worked in the restaurant although there was an issue as to whether he was its manager or acted only as a delivery driver.

2. On 30 December 2016, Ms Megan Lee ordered a meal from Royal Spice using a third party website. She did so with a friend. The friend entered the words "nuts, prawns" in the comments section of the webpage because Megan had what was believed to be a mild allergy to those potential ingredients. Despite that, the food that was provided to her contained peanut proteins. Megan suffered a severe allergic reaction and died in hospital two days later.

3. On 26 October 2018, in the Crown Court at Manchester before Yip J and a jury, the appellant was convicted of manslaughter (count 3) having earlier pleaded guilty to failure to discharge a general duty of employers, contrary to ss. 3(1), 33(1)(a) and 37 of the Health and Safety at Work etc. Act 1974 (count 1) and contravention of EU Food Safety Regulations contrary to Reg. 19(1) of and Sch. 2 to the Food Safety and Hygiene (England) Regulations 2013 (count 2). He was sentenced to 5 months' imprisonment on the first count, 3 months' imprisonment on the second count and 2 years' imprisonment for the offence of manslaughter, all sentences to run concurrently.

4. Mr Rashid faced trial on the same three counts. The jury concluded that he was the manager of the business and convicted him of all three counts. He was sentenced to a total of 3 years' imprisonment. The Company, meanwhile, pleaded guilty to the first two counts and was fined a total of £550 (doubtless assessed because of its inability to meet a larger financial penalty).

5. The appellant now appeals against his conviction for manslaughter by leave of the single judge. No issue was taken either at the trial or in this Court that there was a distinction to be drawn between the Company and that of its sole director, the appellant: we should not be taken as confirming that this approach was correct.

The Facts

6. Many of the relevant facts at trial (including some expert evidence) were presented to the jury as Agreed Facts or by the reading of statements that were not challenged. Some of the medical and other expert evidence was given orally. The summary in this judgment is derived from the Agreed Facts and the summary of the evidence provided by the Judge in the course of her summing up.

7. Mr Rashid had been the registered proprietor of the premises since 2014 and was recorded on the Trading Standards database as being the person in charge at Royal Spice. The appellant (who spoke and read little or no English) considered himself the owner (notwithstanding the separate corporate identity of the Company): he had been its sole director since November 2015.

8. Megan Lee was 15 years old. As a young child she was diagnosed with asthma and was prescribed inhalers to control the symptoms. In early 2010, when aged 8, she was diagnosed with allergies to nuts and other allergens. Her parents were advised to use a certain type of antihistamine on a routine basis and another for more unexpected or pronounced allergic reactions. Megan had not however been prescribed with an adrenaline auto-injector (such as the "EpiPen") or referred for specialist advice about such treatment. Although there was expert evidence that the severity of a previous reaction was not helpful in predicting the severity of future reactions, Megan and her parents understood her allergies to be mild. This fact forms part of the basis of one of the grounds of appeal.

9. On 30 December 2016, Megan and her friend ordered a meal from Royal Spice through a third-party website called "Just Eat". The order included a Peshwari naan, onion bhaji and Seekh kebab, items which did not obviously contain peanuts. During the ordering process the website prompted them with the comment "Leave a note for the restaurant". When this link was clicked, a box opened which allowed the customer to enter text. The box showed sample text, which said "Got an allergy, an address that's hard to find, or a very friendly dog?" In response to this prompt Megan's friend entered the words "Nuts, prawns" in the comments section of the webpage.

10. There was a second link that would have been presented to Megan and her friend when ordering, which said "Do you have an allergy or other dietary requirement?" When this link was clicked, it provided the user with dietary and allergy advice and presented the customer with three options, of which the first was "We strongly advise you to contact the restaurant directly before you place the order." Other options included a live chat facility and an Allergy FAQ section. It is not known if Megan clicked on this link. She did not contact the restaurant direct or use the live chat facility; it is not known whether she used the Allergy FAQ facility.

11. When an order was placed via Just Eat, Royal Spice would receive a printout of the order (including the customer's comments) at its own Just Eat terminal. Royal Spice could then accept or decline the order. Megan's order (including the comment about nuts and prawns) was seen by Mr Rashid. There was evidence before the jury that four other customers had entered comments relating to allergens in the comments box when placing an order during the three months up to and including Megan's order.

12. When an order placed via the Just Eat platform was accepted, Royal Spice would receive a further printout with the customer's contact telephone number. As this was Megan's first order with Royal Spice via Just Eat, instruction was received from the Just Eat platform for Royal Spice to call the customer (who had provided her name, Megan) to confirm the order. Royal Spice did not do so. Nothing turns on this omission.

13. There was no evidence that the order printout or the comments on Megan's order were seen by or passed on to the appellant, who was working as one of the chefs at the time and who prepared the naan. Despite the entry in the comments box being seen by Mr Rashid, the food that the restaurant provided contained peanut protein.

14. Upon eating the kebab, Megan suffered an allergic reaction, which was initially mild. She took an antihistamine and, when she began to feel better, returned to eating the food but avoiding the kebab that had induced the reaction. For a while she did not suffer

any further reaction and when her mother collected her shortly afterwards she did not appear to be in any discomfort save for a rash on her cheek.

15. Shortly after arriving home, however, Megan became distressed, her lips were swollen and blue and she was struggling to breathe. She stopped breathing and her heart stopped. Her mother called an ambulance and she was taken to hospital. Despite the best efforts of her mother, and those of medical staff, Megan suffered irreversible brain damage. On 1 January 2017 her life support was withdrawn and she was pronounced dead. The Home Office Pathologist concluded that Megan's death had been caused by a fatal asthma attack precipitated by an allergic reaction to nuts.

16. In 2014 the local Principal Trading Standards Officer had written to all catering businesses in Lancashire, including Royal Spice. The letter notified businesses of impending changes in legislation and the need to communicate to customers which of their dishes contained allergens (including peanuts). Takeaway businesses were advised that annotating their menus with details of dishes containing allergens or a more general note on a menu or poster reminding consumers to ask about allergens would suffice in informing consumers. A poster was provided with the mailshot which was on display in the restaurant on 6 January 2017. Businesses that took orders without verbal interaction with the customer were advised to keep their menus up to date with information about allergens. The menu uploaded onto the Just Eat platform by Royal Spice contained no information or warning about the ingredients (or any allergens) in the items ordered by Megan. It merely said "Think allergy" and "Please ask member of staff."

17. Experts in Food Safety and Hygiene investigated Royal Spice on behalf of the prosecution and the defendant. They agreed that "Hazard Analysis and Critical Control Point" procedures were not in place or implemented at the takeaway at the relevant time. The "Safe Food, Better Business" system was in place but there was evidence that it was not fully implemented: there were no written procedures in relation to allergen management and staff demonstrated a limited understanding of allergen control. The restaurant did not appear to acknowledge risks from cross-contamination or risks from allergen warnings on pre-packaged ingredients. This failure meant that the complete range of hazards was not fully identified in the minds and practices of staff at Royal Spice.

18. Samples of food and ingredients were taken from Royal Spice on 6 January 2018. Samples taken from a Peshwari naan, an onion bhaji and a Seekh kebab all contained peanut proteins and were assessed to be "unsafe due to the presence of a known allergen."

The Trial

19. The prosecution case against the appellant in relation to manslaughter was that the appellant owed a duty of care to Megan and had failed to take reasonable steps to provide food safe for consumption by a person with allergies. It alleged that the manner in which the business operated demonstrated a lack of concern for the safety of its customers and that there was an obvious and serious risk of death. Peter Wright QC, for the Crown both at trial and in this court, recognised that there was no evidence that the appellant knew about the comment. The prosecution case was that his failure as

owner of the business to introduce systems of allergen control led to the negligent breach of his duty of care. The following points were made on the evidence:

i) The comments section put the appellant on notice that the customer was allergic as the significance of the entry was obvious. No attempt was made to contact the customer.

ii) Inspections undertaken at Royal Spice after Megan's death demonstrated a lack of controls and awareness concerning allergen control.

iii) The food delivered was not properly labelled in respect of allergens and had only indecipherable writing and therefore did not comply with the relevant legal requirements.

iv) Analysis of foodstuffs taken from Royal Spice revealed levels of cross-contamination indicative of a course of conduct resulting in the unsafe food being supplied.

v) The risk of death was asserted to be obvious and it was said to be impossible for the appellant and Mr Rashid to be unaware of it.

20. Mr Rashid gave evidence that he had previously owned and run the business but sold it to the appellant in 2015. In cross-examination he agreed that he knew allergies could be fatal and accepted that he never pointed that out to anyone else. He understood about cross-contamination but never discussed it with staff. He had completed the relevant sections on the SFBB pack and was aware that allergens could be fatal but had not brought the documentation to the attention of the appellant when the appellant bought the business from him. He saw the comment on the order but did not take it too seriously as it did not refer specifically to allergies. He only passed the order slip on without pointing the comment out to anyone, though it is not clear from the evidence to whom the slip was passed. He stated that he was aware that Peshwari naan was made with almonds and coconut but stated that he did not know that almond was a nut. He would have declined the order if it had specifically mentioned allergies.

21. Although he did not give evidence, the appellant's case was that he was the chef responsible for preparing part of the order, but he did not know about the comment on Megan's order and did not know of her allergy. It is not clear that he was even aware of the responsibilities in relation to allergen control placed on a restaurant. It was argued that he was in the same position as another chef who also prepared part of the order but who similarly knew nothing of the comment about nuts and prawns but who was not prosecuted.

The Ruling

22. The appellant submitted during the trial that, as well as being directed on the issue of foreseeability and the risk that must be foreseen, the jury should be directed to consider whether a serious and obvious risk of death in fact existed.

23. The Judge started her ruling by defining the issue as "how the jury should be directed in relation to one of the elements that must be proved by the prosecution on Count 3."

She referred to and set out summaries of principle and further defined the issue that she was considering as follows:

> "4. The issue that arises is in relation to the third element. As identified in *Zaman*, this covers the issue of foreseeability. A defendant can be convicted of gross negligence manslaughter only if a reasonable person in his position would, at the time of his breach of duty, have foreseen an obvious and serious risk of death."

24. Having referred to *Zaman*, *Gurpal Singh*, *Misra* and *Honey Rose* (to which we refer below) the Judge summarised the position on the authorities as follows:

> "7. A review of all the relevant authorities confirms that what must be considered is the reasonable foreseeability of the relevant risk and that this is an objective test. It depends on what a reasonable person would have foreseen at the time on the basis of the information then available to them."

25. It is apparent from these two paragraphs that the Judge considered that she was concerned with the issue of foreseeability. She then, having said that the factual matrix is always crucial in considering how the test is to be applied, set out the Defendant's submission in the following terms:

> "8. Mr Myerson QC, on behalf of the defendant Mr Kuddus, suggests that in this case, in addition to being directed on the issue of foreseeability and the risk that must be foreseen, the jury must also be invited to consider whether a serious and obvious risk of death in fact existed.
>
> 9. He seeks to rely upon evidence that Megan's allergy to nuts had not previously been recognised as being severe. He highlights that Megan had not been prescribed an EpiPen or referred to a specialist, whereas that would have happened had her GP thought there was a serious and obvious risk of death. He also refers to the evidence of the emergency doctor, Dr Rakshi, that this was a very rare, tragic set of circumstances and nothing in the previous history suggested that Megan would have such a severe reaction. He wishes to rely on this medical evidence to suggest to the jury that there was in fact no obvious and serious risk of death in Megan's case."

26. The Judge's reason for rejecting the Defence submission was succinctly stated:

> "10. In my judgment, that is to approach the issue of the seriousness and obviousness of the risk of death from the wrong angle. The issue is not as to the likelihood of Megan dying in light of her medical history. The defendants, of course, knew nothing at all of that history until well after the relevant events. The question is as to the foreseeability of the risk of death at the time of their breach by those in the defendants' position. That involves looking at the circumstances that existed, from their viewpoint, and considering whether a reasonably prudent restaurateur

> would have foreseen a serious and obvious risk of death at the time of their breach of duty."

27. The Judge also considered the following hypothetical situation in which a meal was ordered for two family members with nut allergies:

> "One (A) was known to have a severe allergy, the GP had identified a risk of death if exposed to nuts and prescribed an EpiPen. The other (B) was considered to have a mild allergy and merely told to avoid nuts and take anti-histamines if required. If the restaurant were told of the need to avoid nuts due to allergy but negligently included them in the meal and both family members died as a result, it seemed to me that the effect of Mr Myerson's submissions would be that the restaurateur could be convicted of the manslaughter in respect of A but not B. Mr Myerson confirmed that this would be the outcome on the basis he contended for. With respect, that would seem to me to be a wholly illogical distinction and to illustrate the fallacy of looking at the foreseeability of risk from the perspective of the deceased rather than that of the restaurateur."

28. The Judge concluded that she therefore did not agree with the Defence submission that the directions should be divided into two limbs with the jury being asked to consider separately whether there was in fact a serious and obvious risk of death before addressing foreseeability. She observed that the issue was one of reasonable foreseeability of the relevant risk. In that regard, she did not consider that the question of the factual existence of a serious and obvious risk of death required separate consideration.

Jury Directions and Summing Up the Law

29. The Judge gave the jury written directions on the law which she followed closely when dealing with the law in the oral summing up. In relation to the existence of a duty of care the directions said:

> "25. As a matter of law, the owner and the "Manager" of a takeaway restaurant owe a duty of care to customers to take reasonable steps to ensure their safety, and in particular not to provide food that is harmful to customers with a declared allergy.
>
> 26. … [F]ood containing peanuts should be considered potentially harmful to those with a declared nut allergy.
>
> 27. There is no suggestion that the food supplied to Megan and Katie was in any way unsafe or harmful for customers who did not have a nut allergy. Therefore, when considering Count 3 you will be considering only the duty owed to customers with a declared allergy.
>
> 28. More general duties in relation to food safety including hygiene etc do not have a bearing on Count 3.
>
> 29. For the relevant duty to arise, you must be sure that Megan's allergy to nuts had been declared to Royal Spice. This is a matter of fact for

you to decide, based upon what was communicated to the takeaway and the circumstances in which it was communicated.

30. … You will be looking at this issue from the perspective of a reasonable restauranteur receiving the order, rather than the customer making the order.

31. The question for you is whether what was communicated to Royal Spice and the way in which it was communicated (within the context of the Just Eat system) meant that Megan's nut allergy had been declared to Royal Spice.

32. If you are sure of that, then Mr Kuddus, as the owner, and Mr Rashid, if you have found him to be the "Manager", as a matter of law, owed her a duty to take reasonable steps to ensure that she was not provided with food that contained nuts but was not identified to her as containing nuts.

33. The standard of care required in meeting that duty is that of the reasonable restaurateur. That is an objective test. In considering what is expected of a reasonable restaurateur you will consider all the evidence you have, including that of the experts, … which has been reduced into Agreed Facts."

30. When summing up the "third element" the Judge again followed closely the written directions that she had given to the jury, in which she directed them as follows:

"37. The prosecution must prove that it was reasonably foreseeable that the breach of duty gave rise to a serious and obvious risk of death.

38. The question of whether a serious and obvious risk of death was reasonably foreseeable is to be assessed with respect to knowledge at the time of the breach of duty. Therefore, you must consider what a reasonably prudent restauranteur would have known and understood in December 2016 when an order was received in the terms submitted by Megan and Katie.

39. In addressing this question, you may wish to look at all the background against which Katie entered the words "Nuts, prawns" including the information you have about her medical history. However, in deciding what was reasonably foreseeable to each defendant, you will assess what a reasonably prudent restaurateur in his position, at that time, would have known. Because that is an objective test, it … does not depend on Megan's medical history or anything that only became known after the event.

40. In looking at the case against each defendant in turn, you must consider his role in events and consider the foreseeability of the risk of death in the circumstances he was in.

41. The risk that must be recognisable is nothing less than death, a risk of serious harm falling short of death is not enough.

42. The risk must be clear and unambiguous and not something which might become apparent on further investigation or enquiry.

43. So, if you find that Megan had declared her nut allergy to Royal Spice and that the defendant you are considering failed to take reasonable steps to prevent her being exposed to nuts, the question is whether at the time she was supplied with a meal containing nuts you are sure that a serious and obvious risk of death was reasonably foreseeable to a reasonable restaurateur in his position."

31. Later she added as to the third element:

> "…you must be satisfied that a serious and obvious risk of death was reasonably foreseeable to a reasonably prudent person in the defendants' position. That requires a notional objective exercise of putting a reasonably prudent restaurateur into the shoes of the defendant you are considering and asking whether at the time of the breach of duty that you have found, that person ought to have reasonably foreseen an obvious and serious risk of death."

32. The Route to Verdict on count 3 relating to the appellant was as follows:

"(ii) <u>Are you sure that Megan's allergy to nuts had been declared to Royal Spice?</u>

[See Legal Directions 29 -31]

If no, not sure: find each defendant not guilty; you need go no further

If yes, sure: consider question iii.

(iii) <u>Are you sure that the defendant you are considering failed to take the reasonable steps required of him to ensure that a customer with a declared allergy to nuts would either not be supplied with food containing nuts or would be warned of the nut content?</u>

If no, not sure: not guilty

If yes, sure: consider question iv.

(iv) <u>Are you sure that a reasonably prudent restaurateur would have foreseen a serious and obvious risk of death in the acts and omissions of the defendant you are considering?</u>

[Consider this question on the basis of what a reasonably prudent restauranteur would have known and understood in December 2016 on the basis of the information available from the defendant's perspective. See the directions at section C. for further guidance in approaching this question.]

If no, not sure: not guilty

If yes, sure: consider question v.

(v) Are you sure that the defendant's failure to take reasonable steps to ensure Megan was either not supplied with food containing nuts or was warned of the nut content caused or made a significant contribution to her death?

If no, not sure: not guilty

If yes, sure: consider question vi.

(vi) Are you sure that the circumstances of the defendant's breach were truly exceptionally bad and amounted to such a departure from the proper care to be expected of a reasonable restauranteur as to be considered reprehensible and so properly categorised as gross negligence (i.e. a crime)?

[See the directions at section E. for further guidance in approaching this question.]

If no, not sure: not guilty

If yes, sure (having been sure of all other elements): guilty"

The Principles

33. Different constitutions of this Court have recently summarised in similar but not identical terms what the prosecution must prove in order to secure a conviction for gross negligence manslaughter. Thus, in *R v Honey Rose* [2017] EWCA Crim 1168 the Court said at [77]:

> "77. In the circumstances, the relevant principles in relation to the cases of gross negligence manslaughter can be summarised as follows:
>
> (1) The offence of gross negligence manslaughter requires breach of an existing duty of care which it is reasonably foreseeable gives rise to a serious and obvious risk of death and does, in fact, cause death in circumstances where, having regard to the risk of death, the conduct of the defendant was so bad in all the circumstances as to go beyond the requirement of compensation but to amount to criminal act or omission.
>
> (2) There are, therefore, five elements which the prosecution must prove in order for a person to be guilty of an offence of manslaughter by gross negligence:
>
> (a) the defendant owed an existing duty of care to the victim;
>
> (b) the defendant negligently breached that duty of care;

(c) it was reasonably foreseeable that the breach of that duty gave rise to a serious and obvious risk of death;

(d) the breach of that duty caused the death of the victim;

(e) 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.

(3) The question of whether there is a serious and obvious risk of death must exist at, and is to be assessed with respect to, knowledge at the time of the breach of duty.

(4) A recognisable risk of something serious is not the same as a recognisable risk of death.

(5) A mere possibility that an assessment might reveal something life-threatening is not the same as an obvious risk of death: an obvious risk is a present risk which is clear and unambiguous, not one which might become apparent on further investigation.

78. A further point emerges from the above analysis of the authorities which is particularly germane to the present case: none of the authorities suggests that, in assessing either the foreseeability of risk or the grossness of the conduct in question, the court is entitled to take into account information which would, could, or should have been available to the defendant following the breach of duty in question. The test is objective and prospective."

34. To similar effect, in *R v Zaman* [2017] EWCA Crim 1783 the Court said at [24]:

"The prosecution has to prove the following elements.

(i) In accordance with the ordinary principles of negligence, the defendant owed the deceased a duty of care.

(ii) The defendant was in breach of that duty of care.

(iii) A reasonably prudent person would have foreseen that the defendant's actions or omissions constituting the breach of duty had exposed the deceased to an "obvious and serious" risk of death. The court in *Misra and Srivastava* [2004] EWCA Crim 2375; [2005] 1 Cr Ap R 21 and *Yaqoob* [2005] EWCA Crim 2169 confirmed that the relevant risk to be reasonably foreseen is nothing less than the risk of death.

(iv) The breach of duty either caused, or made a significant contribution (i.e. a contribution that was more than negligible) to, the deceased's death.

(v) The departure of the defendant's conduct from the proper standard of care incumbent upon him, involving as it must have done the risk of

death, was such that the breach of duty can properly be characterised as gross negligence and therefore criminal."

35. Each of these formulations requires the prosecution to prove as the third element that "it was reasonably foreseeable that the breach of that duty gave rise to a serious and obvious risk of death" or, which is slightly different, that "A reasonably prudent person would have foreseen that the defendant's actions or omissions constituting the breach of duty had exposed the deceased to an "obvious and serious" risk of death." The difference is not material given the context provided by the judgment in *Honey Rose* as a whole, the *ratio* of which was identified in *R. v Winterton* [2018] EWCA Crim 2435 as:

> "The question of available knowledge and risk is always to be judged objectively and prospectively as at the moment of breach, not but for the breach."

Each formulation was, in fact, considering what a reasonable person would reasonably have foreseen.

<u>Duty of Care and Breach</u>

36. "The ordinary principles of the law of negligence apply to ascertain whether or not the defendant has been in breach of a duty of care towards the victim who has died": *R v Adomako* [1995] 1 AC 171 at 187B, per Lord Mackay of Clashfern LC. The requirement that the defendant must owe a duty of care to the victim/deceased is common to both summaries of principle cited above. It is not controversial because it is axiomatic as a principle of the law of negligence that "a duty of care … does not … exist in the abstract. A plaintiff who sues for breach of a duty imposed by the law (whether in contract or tort or under statute) must do more than prove that the defendant has failed to comply. He must show that the duty was owed to him and that it was a duty in respect of the kind of loss which he has suffered.": *SAAMCO v York Montagu* [1997] AC 191, 211 per Lord Hoffmann. For present purposes, it is also axiomatic that a working test for when a duty of care is owed is that you must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour.

37. Applying that working test to the context of someone responsible for running a restaurant, such a person is or will be under a duty to take reasonable care to avoid serving food which can reasonably be foreseen would be likely to injure (or cause illness to) persons who may consume it. Although this is expressed as a duty owed to all who may consume the food, the scope of the duty that is owed must be answered by reference to the individual who consumes the food, applying normal tortious principles of the law of negligence.

38. The first two counts on the indictment alleged, respectively, breach of specific provisions of the Health and Safety at Work etc Act 1974 and the Food Safety and Hygiene (England) Regulations 2013. The extensive body of food safety legislation (both primary and secondary) is material to consideration of what steps it is reasonable to expect a restaurateur to take; but it does not (without more) determine the scope of the duty to a particular individual.

39. The scope of the duty owed to any individual will be determined by the circumstances (or, as described in *Honey Rose*, the factual matrix). Thus, a restaurateur must obviously take reasonable steps not to serve food to a customer that is injurious to all and any members of the public. In relation to allergens (such as peanut protein) which may have an adverse effect on a sub-set of the population, the scope of the duty owed to members of the class (or subset) of allergy sufferers may well extend to identifying by warning in a menu or otherwise the presence of such allergens in food with the request that notice be given to the restaurant if, in a particular case, such an allergen is likely to cause harm.

40. Whether such a warning is provided by the restaurant or not, if a customer does alert the restaurant about a harmful allergy, the scope of the duty may then extend to operating a system either to ensure that such identified allergens are not provided or, ultimately, to warning the customer that the restaurant cannot provide food which meets their requirements. If the customer does not give notice to the restaurant of the harmful allergy (particularly when warning has been given on the menu or otherwise), it is difficult to see how the scope of duty could be extended to require the exclusion of all potential allergens in the food provided. Thus, the scope of the duty is fact specific.

41. In opening the case, the prosecution did not make clear that the case against the appellant was entirely based upon his failure to institute proper systems and not based on his reaction (or lack of reaction) when Royal Spice was notified of Megan's allergy. It asserted in very general terms that "the state of affairs that operated and existed at Royal Spice at this time was "nothing short of a disaster waiting to happen, and one to which these Defendants had given little or no thought" and that the manner in which the business was run "were all symptomatic of a state of mind that we say was shared by each of these Defendants as to the lack of concern they had for the safety and well-being of their customers."

42. This approach was reflected in the Summing Up and Written Directions which, having acknowledged that there were "a number of ways in which the duty might be discharged", directed the jury (at [36] of the Written Directions) that:

> "It is the prosecution case that the defendants had taken no reasonable steps to ensure that customers with declared allergies were not exposed to allergens. If you sure that is right, negligent breach of duty would be established."

43. This is such a wide-ranging allegation that it may be said to be unduly favourable to the appellant: the prosecution was undertaking to prove that no reasonable steps at all were taken. But it does not do anything to clarify whether or to what extent the fact that the appellant was not told of the declared nut allergy affected the case against him.

Foreseeability and Serious and Obvious Risk of Death

44. The criminal law of gross negligence manslaughter parts company from the civil law of negligence when it comes to the third requirement: proof of a foreseeable risk of death is not required to establish a tortious cause of action and does not affect the measure of damages that may be recovered in the tort of negligence. Although it is not for this court to decide questions of civil liability, nothing that we say should be taken

as casting doubt on the proposition that Royal Spice (or, more accurately, the Company) would if sued be liable in damages in relation to Megan's death.

45. The criminal law, however, requires that a reasonably prudent person possessed of the information known to the defendant would have foreseen that the defendant's actions or omissions constituting the breach of duty had exposed the deceased to an "obvious and serious" risk of death. That principle can be traced through the authorities starting with the leading case of *R v Adomako* [1995] 1 AC 171 at 187B-C. There Lord Mackay of Clashfern LC, with whom the other members of the House agreed, referred to the risk of death as one of the circumstances to which the jury should have regard when considering whether the seriousness of the Defendant's breach of duty was such that it should be judged criminal:

> "On the basis in my opinion the ordinary principles of the law of negligence apply to ascertain whether or not the defendant has been in breach of a duty of care towards the victim who has died. If such breach of duty is established the next question is whether that breach of duty caused the death of the victim. If so, the jury must go on to consider whether that breach of duty should be characterised as gross negligence and therefore as a crime. This will depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred. The jury will have to consider whether the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him, involving as it must have done a risk of death to the patient, was such that it should be judged as criminal.
>
> It is true that to a certain extent this involves an element of circularity, but in this breach of the law I do not believe that is fatal to its being correct as a test of how far conduct must depart from accepted standards to be characterised as criminal. This is necessarily a question of degree and an attempt to specify that degree more closely is I think likely to achieve only a spurious precision. The essence of the matter which is supremely a jury question is whether having regard to the risk of death involved, the conduct of the defendant was so bad in all the circumstances as to amount in their judgment to a criminal act or omission."

The existence of a risk of death was thus linked to (but treated as separate from) the further requirement of gross negligence; it is obviously significant when determining the question whether the seriousness of the breach was such that it should be considered gross negligence and criminal.

46. In *R v Gurpal Singh* [1999] Crim L.R. 582, this Court endorsed (as a model direction) a summing up which included the following:

> Was the negligence which caused the death gross negligence? The question posed is: Having regard to the risk of death involved, was the conduct of the defendants so bad in all the circumstances as to amount, in your judgment, to a criminal act or omission? The circumstances must be such that a reasonably prudent person would have foreseen a serious

and obvious risk not merely of injury or even serious injury but of death. If you find such circumstances in the case of the defendant whom you are considering you must decide whether what he did or failed to do was so bad that it was criminal. That, of course, means that the degree of negligence of which he was guilty was very high."

47. The Judge had returned to the same point when concluding his summing up, as follows:

> "… [W]as the negligence which caused the death gross negligence? The question posed is, having regard to the risk of death involved was the conduct of the defendants so bad in all the circumstances as to amount in your judgment to a criminal act or omission. The circumstances must be such that a reasonably prudent person would have foreseen a serious and obvious risk not merely of injury, even serious injury, but of death. …"

48. The linking of the requirement for an obvious and serious risk of death to the proof of gross negligence was continued in *R v Misra* [2004] EWCA Crim 2375 at [25], where the trial Judge's summing up had included the following passage:

> "Mistakes, even very serious mistakes, an errors of judgment, even very serious errors of judgment, and the like, are nowhere near enough for a crime as serious as manslaughter to be committed. If you do conclude that you are sure that either or both of the defendants have been in breach of their duty of care in their treatment of Sean, you must therefore go on to consider the nature of that carelessness or negligence, as you find it to be.
>
> Over the years, the courts have used a number of expressions to describe this vital element of the crime, but the key is that it must be gross in the perhaps slightly old-fashioned sense now of the use of that word. So in this case, when you are considering the conduct of each doctor, I think you will find it most helpful to concentrate on whether or not the prosecution has made you sure that the conduct of whichever one you are considering in all the circumstances you have heard about and as you find them to be, fell so far below the standard to be expected of a reasonably competent and careful senior house officer that it was something, in your assessment, truly exceptionally bad, and which showed such an indifference to an obviously serious risk to the life of Sean Phillips and such a departure from the standard to be expected as to amount, in your judgment, to a criminal act or omission, and so to be the very serious crime of manslaughter."

49. A second feature that recurs in the authorities is that what must be reasonably foreseeable is a serious and obvious risk of the death of the person to whom the defendant owed the duty, breach of which was a cause of that person's death. That is expressly made clear by the passages from *Adomako*, *Misra* and *Honey Rose* to which we have referred above. It is also implicit in the observations of the trial Judge and this Court in *R v Rudling* [2016] EWCA Crim 741 at [23] and [38-40]:

“23. There was little dispute that, with the benefit of hindsight, had a doctor seen Ryan by the early evening of Friday 7 December 2012, he or she would have seen and assessed a very sick boy. The judge went on, however, that it is not the assessment which would have been made at the visit which goes to the risk envisaged in the legal test; rather, it is the risk at the time of the telephone call. The judge then applied that test to the facts as they were or ought to have been known to Dr Rudling at the time of the phone call, together with the evidence of Dr Peter as to when the assessment that Ryan’s illness was obviously life-threatening is likely to have been made, coupled with Professor Hughes’ evidence that hyper-pigmentation was not, in itself, indicative of the adrenal crisis phase of Addison’s disease. She then concluded, in respect of this aspect of the element of the test of gross negligence manslaughter, that the prosecution had not provided specific evidence that, at the time of the telephone call, a reasonably prudent person would conclude that an obvious and serious risk of death to Ryan Morse was present.

…

38. The nub of Mr Price’s argument was that if it is necessary to have a face to face assessment in order to risk manage a patient and assess what might potentially be a life-threatening condition, it is necessarily implicit that there is an obvious and serious risk of death at that time. As he put it, the thrust of Dr Peter’s evidence was that a reasonably competent GP would have said to himself/herself “I cannot eliminate the possibility that this child may be suffering from a rare risk to life without the child being seen urgently” and that that equates to an obvious and serious risk of death.

39. In our judgment, that proposition simply does not follow, as is apparent when one focuses on each of the three aspects of this ingredient of the offence of gross negligence manslaughter. At the time of the breach of duty, there must be a risk of death, not merely serious illness; the risk must be serious; and the risk must be obvious. A GP faced with an unusual presentation which is worrying and undiagnosed may need to ensure a face to face assessment urgently in order to investigate further. That may be in order to assess whether it is something serious, to use Dr Peter’s expression., which may or may not be so serious as to be life-threatening. A recognisable risk of something serious is not the same as a recognisable risk of death.

40. What does not follow is that if a reasonably competent GP requires an urgent assessment of a worrying and undiagnosed condition, it is necessarily reasonably foreseeable that there is a risk of death. Still less does it demonstrate a serious risk of death, which is not to be equated with an ‘inability to eliminate a possibility’. There may be numerous remote possibilities of very rare conditions which cannot be eliminated but which do not present a serious risk of death. Further, and perhaps more importantly, a mere possibility that an assessment might reveal something life-threatening which is not the same as an obvious risk of death. An obvious risk of death is a present risk which is clear and

unambiguous, not one which might become apparent on further investigation."

50. It is established that the seriousness of the breach of duty committed by the defendant should take into account all the circumstances in which the defendant was placed when the breach occurred: see *Adomako* at 187H, cited above. Furthermore, both on authority and in principle, the primary focus in a case of gross negligence manslaughter will normally be on the foreseeable consequences of the Defendant's breach of duty for the person to whom the duty was owed.

51. Both *Rudling* and *Honey Rose* were cases about foreseeability. In neither case was there any real dispute that, if further investigations had been carried out, there was a serious risk of death for the victim that would have been revealed. Similarly, in *Zaman* the appellant conceded that there was a serious and obvious risk of death, a concession that was described as inevitable: see [66]. The decisions in *Rudling* and *Honey Rose* establish that the question whether it is foreseeable that there is a serious and obvious risk of death must exist at and is to be assessed with respect to the information available to the defendant at the time of the breach of duty: see *Honey Rose* at [77(3)], and [94]. The fact that the cause of a defendant's lack of foresight of a serious risk of death for the victim was his or her own breach of duty is not to point: see *Honey Rose* at [91]; and this decision was carried over to limit the imputed foresight of the notional reasonable prudent person in the defendant's position.

52. What can be foreseen by a reasonably prudent person, along with the existence and seriousness of risk of death must be determined at the time of breach of duty. In this case, that is at the time of the supply to Megan of food containing peanut protein. That is when the appellant's failure to act with reasonable care caused damage and is also the time at which the quality of the appellant's breach falls to be assessed for the purposes of gross negligence manslaughter involving as it does an assessment of any risk and whether a reasonably prudent person in the appellant's position would have foreseen that the appellant's actions or omissions constituting the breach of duty had exposed the deceased to an "obvious and serious" risk of death. As both *Rudling* and *Honey Rose* make clear, it is not proved by the fact of death.

53. Although the third element in both *Honey Rose* and *Zaman* is primarily concerned with foreseeability, it is implicit (and is made explicit at [39] of *Rudling*, cited above) that the Defendant's breach of duty must give rise to (1) a risk of death, that was (2) obvious and (3) serious. These are objective facts, which are not dependent upon the state of mind or knowledge of the Defendant. If there is a real issue as to their existence, each must be proved by relevant and admissible evidence.

54. In any case of gross negligence manslaughter there is, by definition, a risk of death, because it must be proved that the Defendant's breach caused the death of the victim. Whether the risk of death was obvious is also a question of fact. It is important in two related contexts: first, whether the risk would be foreseen by a prudent person standing in the shoes of the Defendant; and, second, for the jury to take into account when considering whether the Defendant's breach was so serious that it should be regarded as criminal. The seriousness of the risk of death, as an objective fact, is itself a question of fact and is distinct from the question whether a reasonable person in the Defendant's position should have foreseen that the risk was serious (and obvious). As we have said, each of these objective facts is distinct from the question of foreseeability that was in

issue in *Honey Rose* and *Zaman*: put simply, you cannot foresee something that does not exist.

55. This appeal raises a different question, namely whether, antecedent to reasonable foreseeability of a serious and obvious risk of death, the prosecution must prove, *in relation to the particular victim concerned*, that there was, in fact, a serious and obvious risk of death which itself would depend on the particular circumstances of the victim. We will return to this argument when dealing with the grounds of appeal.

Gross Negligence

56. The final ingredient of the crime of gross negligence manslaughter concerns the nature of the negligence to be proved. The Judge identified the position in her route to verdict requiring the jury to be sure that the negligence was truly exceptionally bad and amounted to such a departure from the proper care to be expected of a reasonable restaurateur as to be considered reprehensible and so properly categorised as gross negligence (i.e. a crime). This direction follows that identified in *Adomako*, *R v Sellu* [2016] EWCA Crim 1716, [2017] 1 Cr App R 24 and the cases cited above. No point is taken about this aspect of the case and we need to say no more about it.

The Appeal

57. Simon Myerson Q.C. for the appellant advanced two grounds of appeal. The first was that Yip J was wrong to refuse to direct the jury that they needed to consider whether there was, in fact, a serious and obvious risk that the appellant's breach of duty would cause Megan in particular to die (as opposed to others more generally who might be suffering from peanut allergy). In advancing the first ground Mr Myerson drew a distinction between the foreseeability of risk and the existence of risk. He did not challenge the established principle that foreseeability was to be assessed from the perspective of the individual defendant, but he submitted that the existence of risk in relation to the victim was a matter of fact which the jury in this case should have been directed to consider separately.

58. He advanced several reasons in support of this proposition. First, he argued that it was a fact which the prosecution had to prove if, as in this case, it was not conceded (although he cited no authority for this assertion). In that context, however, he argued that the prosecution had in fact adduced relevant evidence. Second, he submitted that it was contrary to logic and justice that an individual could be convicted on the basis that a reasonable person should have foreseen a serious risk of death unless that level of risk actually existed. Finally, he argued that the Judge's ruling treated the distinction created in the hypothetical example which she gave as "wholly illogical" because the trial judge focused on foreseeability rather than actuality of risk to the exclusion of the issue that the appellant sought to raise. He submitted that, because the jury was not directed as he had proposed, the factual existence of a serious risk of death was implicitly assumed and was not effectively left to the jury to decide. In his submission, in the present case, the requisite serious and obvious risk of death did not in fact exist.

59. Although the Grounds of Appeal are expressed in general terms, submitting that the Judge should have directed the jury that "they must … be sure that there was [a serious and obvious risk of death in the acts and omissions of the Appellant]", Mr Myerson's presentation of this ground of appeal was consistent with his submissions to the Judge

as recorded at [9] of her ruling, set out at [26] above. The significance of this is that he was submitting that the jury should be directed to consider whether Megan herself was exposed to serious risk of death by the appellant's breach of duty (as opposed to members of the class of individuals who suffered from nut allergies).

60. Mr Wright responded that the trial judge correctly identified the test, and in any case, addressed the existence of risk by asking question (iv) in the Route to Verdict: the matter was not withdrawn from the jury. The evidence that had been called had specifically addressed the issue of causation, namely that the ingestion of the food had, in fact, caused or materially contributed to death. Rather, he argued that the appellant's proposed approach would lead to the illogicality described in the ruling.

61. At the heart of the first ground of appeal is the question whether this is a case where the appellant was entitled to argue before the jury that the medical evidence about Megan herself meant that she herself was not exposed to a serious risk of death. In support of that submission, and although it was not denied that she died as a result of an anaphylactic reaction to peanuts, the appellant wishes to rely upon the evidence of Dr Raqshi (of which the jury were reminded), who observed that her case was a very rare, tragic set of circumstances and that there was nothing in her history to predict such a severe reaction.

62. To do justice to the submission, it is appropriate to set out the medical history of Megan which was put before the jury in these terms:

> "You heard that Megan was generally well, but had quite bad asthma. As she got older she managed this herself well with inhalers. She did have exacerbations, usually a couple of times a year.
>
> In 2010 her parents had suspected that she was allergic to a number of things, including nuts, but possibly also animals, strawberries and tomatoes and so she underwent blood tests and the results showed a reaction to a nut panel which included peanuts, hazelnuts, Brazil nuts, almond and coconut. She also had reactions to cats, house dander, dust mites and grouse pollen, but not to dogs, strawberries and tomatoes.
>
> You may remember that Dr. Eccles explained that these results do not actually diagnose allergies, although the higher the so-called IgE result the more likely that the patient will have an allergic reaction to the substance that she has been tested for. However, medics do not fully understand how levels of IgE relate to the severity of reactions and it is hard to predict whether someone is likely to have a mild reaction, like a rash, or a more severe one, so, essentially, a positive test result is a warning, but it is hard to predict how an individual will in fact react.
>
> After a discussion with Megan's parents, Dr. Houlstead prescribed the use of over-the-counter medications. Benadryl to be used more regularly and Piriton if that did not work. Megan was never prescribed an EpiPen or anything similar, nor was she referred to a specialist.
>
> Dr. Eccles thought that Dr. Houlstead's advice had been reasonable. There was no history of Megan ever having a severe reaction before and

there was nothing in the history that suggested she should have an EpiPen. She should have been advised to stay away from the substances she had shown a reaction to; to use antihistamine medication, if she was exposed, and to seek urgent medical treatment if a reaction ever became severe.

Dr. Eccles said that there had been new guidelines on managing allergies in the under nineteens in 2011, but that was after Megan was seen and it does not appear from her records that her allergy management was reviewed later.

We heard that Megan had had a reaction to a prawn cracker about five-years before her death and as her mum was allergic to prawns, they thought Megan might be as well, so they avoided giving her prawns.

Megan's parents always understood that her allergies were mild and had never been aware that they might lead to her death. You might think that that fits also with Katie Bracegirdle's evidence that Megan never made her allergies into a big issue. She did not check on the back of packing, for example. Katie said that she did steer clear of nuts, although she would eat things like chocolate and she would not say: "I have to check there are no nuts in it."

When they were ordering from Royal Spice and Katie asked Megan about her allergies, Katie told you that Megan said: "Oh, it doesn't matter, it's not a big deal, I don't have an issue." When Katie insisted they put what she was allergic to down, Megan told her nuts and prawns", but she said: "There won't be anything in it, it'll be fine, it's not too bad" type of thing.

Megan's parents told her schools about her allergies, but there was never any suggestion from doctors or teachers that she should have an EpiPen. They never sought a second opinion as they did not think there were any issues."

63. The Judge also reminded the jury about the second set of Agreed Facts in relation to the expert medical evidence in the following terms at 26B-G:

"They confirm that Megan was not prescribed with an EpiPen or other adrenalin auto-injector. Such devices are prescribed to patients who have had or who are thought to be at risk of a severe allergic reaction, but there is great variability in the prescription of such devices.

… The Agreed Facts record that the mainstay of allergy management is the avoidance of triggering allergens. It is possible, it is said, that specialist allergy clinic review with detailed avoidance strategies, structured advice on acute allergy management and carriage and proper use of an adrenalin auto-injector could, potentially, have led to a different outcome. However, death from anaphylactic [shock] can

> occur, despite all that, so it is difficult to ascertain whether such measures would in fact have led to a different outcome.
>
> In terms of where that evidence takes you, … you may wish to take account of the evidence about Megan's allergies and the fact that she was apparently not someone who was thought to be at risk of a severe allergic reaction, as part of the background when you are considering the information given to Royal Spice."

64. The Judge then turned to the investigations that had been carried out and the rest of the factual background to the trial. Turning to the trial the Judge summarised the relevant passage from Mr Rashid's evidence at 45C:

> "He agreed he knew about allergies, knew they could be dangerous and that people with nut allergies can die if exposed to nuts. He accepted that he never pointed that out to Mr. Kuddus or to anyone else."

65. Further evidence was provided in the Agreed Facts which included the conclusions of experts in Food Safety and Hygiene about good practice for those running restaurants and identified clear evidence of breaches of good practice by Royal Spice including:

> "It is expected that food businesses know their obligations to provide safe food and to control any microbiological, chemical and physical risks present within their kitchens when preparing food. This knowledge could be obtained from food hygiene training and the FSA's Safer Food Better Business Catering pack."

However, although they referred to the existence of hazards and that "they were not fully identified in the minds and practices of staff at Royal Spice" the Food Safety and Hygiene experts gave no evidence about the existence of a risk of death or its seriousness in the events which happened.

66. The Agreed Facts also reflected a meeting of three experts (a consultant immunologist, a consultant paediatric allergist, a professor of clinical immunology and allergy) who took into account the report of a GP with expertise in how GPs treat allergy. Their Agreed Facts included the following:

> "5. Adrenaline auto-injectors are prescribed to patients with allergies if they have had or are thought to be at risk of severe allergic reactions. Common devices in the UK include Epi-pens. Megan had not been prescribed such a device or referred for specialist advise about such a device.
>
> 6. Dr Doyle noted that there is great variability in the prescription of such devices by both GPs and Consultant Allergists. …
>
> 7. There is research evidence that such devices are not used correctly in up to 50% of emergencies, and that death can occur despite the use of an EpiPen or an alternative adrenaline autho-injector.
>
> …

> 10. … Professor Powell in his initial report had made clear that the severity of a previous reaction is not helpful in predicting future reaction severity. …
>
> 12. The three specialist experts agreed that teenagers and young adults predominate in studies of fatal allergic reactions, and the majority of severe non-fatal allergic reactions, and the majority of severe non-fatal accidental reactions occur in this age group. Those individuals most at risk of a severe reaction from allergy to peanuts or tree nuts, are those with asthma, especially if poorly controlled, and young adults transitioning to independent living. Megan fitted such a profile. Recognition of this profile, particularly in those with background asthma, requires consideration for prescription of a self-injectable adrenaline device (such as an EpiPen) with appropriate training so that appropriate emergency treatment is available should allergic reactions occur."

67. At the hearing of this appeal, Mr Wright was invited to submit any further evidence that was before the jury and which went to the issue of risk of death. No further medical or other expert evidence was submitted, though it is apparent that there were disclosed reports that underpinned the Agreed Facts. Documents submitted included extracts from documents that had been supplied to Royal Spice by the local authority to assist it to comply with its legal requirements by conforming with HACCP (hazard analysis critical control point). For the purposes of the present issue the relevant statements in the documentation were:

    i) In a section entitled "Safe method: food allergies":

    > "It is important to know what to do if you serve a customer who has a food allergy, because these allergies can be life-threatening";
    >
    > "If someone has a severe allergy they can react to even a tiny amount of the food they are sensitive to";

    ii) In a section entitled "Safe method: Training and supervision":

    > "What to do if things go wrong …. Ring 999 and ask for an ambulance with a paramedic straight away."

68. Mr Myerson argues that this review shows that there was no focus on the existence or seriousness of a risk of death for Megan arising from the appellant's breach of duty, either by reference to the incidence or risk of death in the general population, or in the population having allergies, or to Megan specifically. To the extent that there was any relevant evidence at all it was to the effect that (a) what had happened was a very rare occurrence and (b) the consensus medical view before the fatal ingestion (which was shared with and by Megan and her parents) was that Megan was subject to a mild allergy with no suggestion that it might lead to her death. This was reinforced by the evidence that EpiPens are prescribed to patients with allergies if they have had or are thought to be at risk of severe allergic reactions, and Megan was not considered to be in that category. The only other evidence was the statement by Professor Powell in his initial report that the severity of a previous reaction is not helpful in predicting future reaction severity.

69. In our judgment, to focus on the particular circumstances of this specific victim is to misunderstand what has to be established to prove gross negligence manslaughter. There is no requirement that there must be proved to be a serious and obvious risk of death for the specific victim who dies. If it is in issue, the question to be answered is whether the defendants' breach gave rise (as an objective fact) to a serious and obvious risk of death to the class of people to whom the defendant owed a duty. Thus, in the present case, where the duty was to take reasonable steps not to injure members of the class of nut allergy sufferers (of whom Megan was one), the question to be answered would be whether any proved breach by the appellant would give rise to a serious and obvious risk of death for members of that class.

70. Thus, to be specific to this case, if, for members of the class of nut allergy sufferers, there was, in fact, a serious and obvious risk of death, it would be no answer to the prosecution that Megan's medical advisers had assessed the level of risk of an allergic reaction in her specific case to be low or that, as a consequence, on the face of that advice, she was only at risk of injury rather than death. The restaurant did not have this detailed information about its customer and, although whether the subsequent risk of death was foreseeable to a reasonable chef possessed of the information available about the particular vulnerabilities of the victim will be relevant to foreseeability and, potentially, gross negligence, on the basis that Mr Rashid conceded that he knew that people with nut allergies could die if exposed to nuts, he was under a duty to act accordingly.

71. The fact that the doctors did not think that the risk for Megan was such that she required an EpiPen is not to the point. In the absence of special circumstances, none of which arise in the present case, the relevant question in this case would be whether the appellant's breach gave rise to (a) a risk of death that was (b) serious and (c) obvious for nut allergy sufferers of the class to whom the relevant duty was owed and of which Megan was a member. That question, if asked, should be answered by reference to all relevant and admissible evidence.

72. For these reasons we consider that the submission advanced by Mr Myerson QC before the trial judge was mistaken because it over-personalised the question of fact that he submitted should be left to the jury. We therefore endorse the Judge's decision not to direct the jury in accordance with his submission. There was no separate and independent requirement that the Crown prove that the particular victim, in this case Megan, was at serious and obvious risk of death. The individual idiosyncrasies of individuals at potential risk, on the assumption that they will be unknown to the defendant, cannot determine the question whether there is in fact a serious and obvious risk of death. We leave open the different issue, which does not fall for decision in this case, whether and if so when personal knowledge on the part of a defendant of the characteristics of the specific person to whom a duty is owed may affect the answer to that question.

73. We have prefaced this part of our decision by saying "if it is in issue…". As we have already indicated, in many cases (of which *Rudling*, *Honey Rose* and *Zaman* are examples) it will not be in issue that the defendant's breach of duty gave rise to a serious and obvious risk of death. It is not clear to us whether the factual existence of a serious risk of death itself (as properly understood) was in issue in this case. Furthermore, because the Judge rightly declined to direct the jury on the erroneous basis advanced by Mr Myerson, we are not confident that the Agreed Facts and evidence in the

summing up provide a full and comprehensive account of the evidence that was available to the jury if the existence of a serious risk of death (in the sense that we have explained) was in issue.

74. Because of our decision on Ground 2 of the appeal, to which we turn next, we consider that the correct course is to rule that the Judge was right to reject the over-personalised submission being advanced by Mr Myerson. It is not necessary to call for further assistance or clarification from the prosecution or the defence. It is merely necessary to repeat that *if* the factual existence of a serious and/or obvious risk of death is in issue in future (which may be a rare case), that should be clearly identified and, if not conceded, is a necessary fact that must be proved by relevant admissible evidence.

75. The second ground of appeal was that the Judge wrongly directed the jury in terms which equated the knowledge of the business (or Mr Rashid) with that of the appellant; this was on the basis that the appellant was responsible for the system in the restaurant. Mr Myerson contended that the effect of the judge's directions, in particular paragraph 29 of the legal directions (see [29] above), was to treat the appellant as being subject to a duty of care so long as the allergy was declared to the business and even if the declaration was made without the knowledge of the appellant. He argued that regardless of the propriety of imputing knowledge in the context of the regulatory offences, such imputation was incorrect in the context of manslaughter. It was not the prosecution case that negligence on the part of the appellant lay in a failure to ensure he was informed.

76. Further, the judge's directions referred to those in control of the business compendiously and did not distinguish between Mr Rashid, who knew of the allergy, and the appellant, who did not. The effect of this would have been that the jury could have concluded that actual knowledge was irrelevant to all issues concerning gross negligence manslaughter.

77. On the second ground Mr Wright submitted that the existence of a duty of care was neither dependent on personal knowledge nor owed to specific customers (although, for our part, we do not understand how it could be owed otherwise than to all customers including 'specific' ones). In any event, he submitted that as the declaration was made to the business and the duty was owed by the owner, no vicarious liability was entailed. In any case, the jury were reminded of the appellant's ignorance of the allergy when considering whether he breached the duty of care owed and if so how. Mr Wright also relied on the fact that the prosecution case was not dependent on the appellant's knowledge of the declared allergy, pointing to his contention that the duty owed was wider than only to those customers who declared allergies.

78. There is no doubt that the scope of any defendant's duty is fact-sensitive. The Judge rightly directed the jury that they should consider the charge of manslaughter against each defendant separately and return separate verdicts against each. However, in relation to manslaughter, the summing up treated giving notice of allergy to "Royal Spice" as sufficient to demonstrate notice to both Mr Rahsid and to the appellant. No difficulty arises in relation to Mr Rashid because it was common ground that he received the form of order with the words "nuts prawns" clearly marked on it. However, the position with the appellant was different as there was no evidence that he was notified about the terms of the order: indeed, it seems to have been common ground that he was not.

79. In our judgment, the fact that the appellant was the sole director of the Company placed upon him the duty of ensuring that appropriate systems were in place to avoid the risk that a customer with a declared allergy was not served food which contained the allergen. That is the same as the duty placed in *Honey Rose* of conducting an appropriate examination to accord with the requirements of the legislation. In both cases, the risk, however, was the risk that a customer or patient respectively might present with the underlying condition which the system should have been designed to prevent, rather than the obvious and serious risk of death. To put it more generally, if a reasonable person possessed of the knowledge available to the defendant would have foreseen only a chance that the risk of death might arise, that is not enough to justify a conviction for gross negligence manslaughter. What is required is that the reasonable person would have foreseen an obvious and serious risk of death.

80. Using the same two examples of this case and *Honey Rose*, the foreseeable risk for the purposes of gross negligence manslaughter is that, armed with notice that a particular customer or patient falls into the category which the system (or statute) was designed to deal with, a reasonable person in the position of the restaurateur or optometrist would, at the time of breach of duty, have foreseen an obvious and serious risk of death. It is in those circumstances that the jury would have to go on to consider whether the negligent breach of duty was ‘gross’ within the meaning of that term defined by the authorities.

81. The difficulty with the approach in this case was that it was not suggested that the appellant was armed with notice that Megan fell into the category of those in respect of whom a reasonable person in the position of the appellant could have foreseen an obvious and serious risk of death by serving the food that he did. He knew nothing of the allergy which she had declared. In those circumstances, the conviction for gross negligence manslaughter cannot stand.

82. This is not to say that the responsibilities of the owner of a restaurant can be ignored, simply by ensuring that he or she is unsighted on the specific orders and allergy requirements being made. In addition to liability in negligence, unless an appropriate system is in place and enforced, the owner or manager would also be guilty of the other offences of which both the appellant and Mr Rashid were convicted.

83. Nor is it to suggest that, in an appropriate case, a person could not properly be convicted for a failure to introduce appropriate protective systems either in the context of restaurants or elsewhere or that need for knowledge could be used unjustifiably to relieve from liability those in charge of restaurants or other businesses at the expense of those on the front line.

84. There is now a general awareness of the potential risks to those who suffer from allergies and, as a result, it should be understood that the courts will rigorously scrutinise the way in which restaurants discharge the duty of care that they owe to such customers. However, in a case where (a) (as now clarified) the case against the appellant – who spoke little English and had only taken over the restaurant from Mr Rashid the previous year in circumstances in which Mr Rashid continued to manage it – was based solely upon his failure to introduce appropriate systems at a time when he knew nothing of prospective customers’ allergies and (b) there was no evidence that he was at any stage notified of Megan’s allergy, the direction to the jury on attribution of knowledge renders his conviction unsafe for the reasons we have given.

Conclusion

85. We pay tribute to the exceptional care that Yip J paid to this difficult case. In relation to the first ground upon which Mr Myerson pursued an appeal, we conclude that she was correct to rule as she did for the reasons that she gave. In relation to the second ground, she accepted the submissions of the Crown for reasons which we understand but which, in our judgment, failed to recognise the difference between the general duty owed by the appellant as 'the owner' (ignoring the impact of the intervention of the Company) or, perhaps more accurately, the director with responsibility for ensuring that appropriate safety systems were put in place to protect those with declared allergies and the duties of those responsible for ensuring that appropriate steps were taken in relation to those who did declare such allergies.

86. In the circumstances, the appeal is allowed and the conviction for gross negligence manslaughter is quashed.