

SCOTLAND / JUDGMENT

Smith v HM Advocate [2016]

ScotHC HCJAC_67 (19 August 2016)

[2016] ScotHC HCJAC_67

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[2016] ScotHC HCJAC_67 [New search] [Help] APPEAL COURT, HIGH COURT OF JUSTICIARY

[2016] HCJAC 67 HCA/2016/19/XC Lord Justice General Lady Paton Lord Malcolm OPINION OF THE COURT delivered by LORD CARLOWAY, the LORD JUSTICE GENERAL in NOTE OF APPEAL AGAINST CONVICTION by GEORGE DONALD SMITH Appellant ; against HER MAJESTY'S ADVOCATE Respondent : Appellant: J Carroll, Solicitor Advocate, McLaughlin; John Pryde & Co Respondent: A Prentice QC (sol adv); the Crown Agent 19 August 2016

Introduction

- [1] On 27 October 2015, at the High Court in Glasgow, the appellant was convicted of a charge which libelled that: “on 7 December 2014 at Flat 1/2, 101 Stravanan Road, Castlemilk, Glasgow, and the common close there you ... did assault Steven Larkin ... and did punch, kick and stamp on his head and body, otherwise inflict blunt force injuries on his head and body, the exact means by which you did so being to the Prosecutor unknown, drag him from said flat onto the landing, compress his neck with a scarf or by other means and you did murder him.” On 6 January 2016, he was sentenced to imprisonment for life, with a punishment part of 14 years.
- [2] The central issue at trial was whether the deceased had been killed by asphyxia as a result of pressure or blows to the neck, as distinct from, for example, hypothermia, or succumbing to the effects of a combination of excessive quantities of alcohol and drugs. There are three grounds of appeal, all related to this issue. The first is whether the trial judge erred in repelling a submission that there was insufficient evidence of asphyxia as the cause of death. The second is whether the judge failed adequately to direct the jury that it was essential for a conviction that the cause of death was proved to be asphyxiation by the appellant. The third is whether the verdict of guilty was one which no reasonable jury could have returned. These issues involve a consideration of the lay and medical evidence heard at

trial. Evidence Lay

- [3] The deceased was found in the early hours of Sunday, 7 December 2014 lying on a first floor landing, outside the appellant's flat. There was blood on his face and in the surrounding area. His scarf was tied very tightly around his neck.
- [4] RH, the appellant's downstairs neighbour, spoke to being at home on the Saturday night (6 December). At about 9.00pm, Mr H had seen the deceased coming into the close with a carrier bag and going upstairs towards the appellant's flat. He was watching a film when he heard rumbling noises from upstairs. Prior to this he had heard the voices of both the deceased and the appellant. They had been playing records until at about 1.00am. A crashing sound had come from upstairs as if furniture was being upturned and "stuff was being smashed". He heard the appellant shouting once or twice: "Get out my f...ing house". He adopted part of a statement, which he had given to the police, that it sounded as if the appellant had been "rolling about with someone, fighting with them, by the way this crashing noise continued". This was hours after the music had been turned off.
- [5] Mr H had been disturbed by DS (who also gave evidence) at about 4.00am. Mr S had gone upstairs. He then re-appeared and asked Mr H to telephone for an ambulance. Mr H had gone upstairs and found the body of the deceased. The appellant walked out of his flat door at this point and said: "Have you got a cigarette on you please, I think I've done him in". He appeared mesmerised, as if he did not know what was happening or where he was. He was, however, talking about the deceased. A statement was put to the witness that what he had said was "I think he's deid, I think I've killed him". He agreed with this, although his statement had erroneously recorded that the appellant had gone to Mr H's door, rather than this occurring at the appellant's flat.
- [6] The appellant made no material comment at interview and did not give evidence.
- Professional
- [7] Dr Marjorie Turner, consultant forensic pathologist at Glasgow University, spoke to her report on the post mortem examination. The cause of death was certified as being "head and neck injuries and cocaine and alcohol intoxication". The deceased's medical history had included alcohol detoxification in October 2014 and opioid drug dependency in April 2014. He had been prescribed a variety of drugs. He was a young man who, Dr Turner agreed in cross-examination, might be unsteady on his feet and fall over.
- [8] Dr Turner had noticed a number of petechiae in and around the eyes, one cause of which could have been asphyxia, although they might less commonly have been post mortem changes. Where a pathologist saw petechiae, particular attention would be paid to anything that might have caused that, such as compression of the neck, obstructing the airways and depriving the lungs, and hence the blood, of oxygen. There was a ligature mark (pallor) on the deceased's neck where his scarf had been. Dr Turner had cut the scarf away. It was not possible to tell if the mark had been a significant factor in the death, but the scarf was tied tighter than a person would wear it. It could have caused asphyxial problems.

- [9] The deceased had suffered blunt force injuries to his face and scalp with bruising reflecting impacts to and around both eyes and ears, with scattered small abrasions and lacerations. The force used was in the mild to moderate range and caused by blows with hands or feet or an impact with a hard surface, such as a floor. There were two larger lacerations to the left eyebrow and bruising and abrasion to the left cheek and mouth. The deceased had bruising to his abdomen, which was older than the facial injuries. He had relatively recent bruising of his arms, wrists and hands, which could have occurred at the time of the incident or some hours earlier. The bruises to the hands and arms could have been defensive or indicative of being gripped or held. He had a healing laceration of his right lower shin, a bruise on the knee, and a healing lesion to the ankle, again being older wounds. He also had old bruising or abrasions of the left knee and shin.
- [10] Internally, the deceased had two small linear fractures on the roof of the left orbit, together with bruising on both sides of the tongue, which could be a feature of asphyxia where the tongue was caught within the teeth. There was a fracture of the larynx on the left, with a small amount of associated bruising, and a probable partial fracture on the right. There was a fine linear fracture, with a small amount of associated bruising, of the thyroid cartilage. The hyoid bone was deformed, but intact. The larynx, thyroid cartilage and hyoid bone are vulnerable to fracture if the neck is compressed. Some sort of pressure or blunt injury had accordingly occurred to the Adam's apple area.
- [11] There were significant quantities of alcohol in the deceased's blood and urine, as well as products of cocaine, cannabis, buprenorphine and diazepam. The stomach lining had a few erosions (tiny ulcers), which could be non specific or a feature of hypothermia. There were no other findings associated with hypothermia, although it could not be excluded as a "potential factor" in the death.
- [12] Dr Turner noted that Professor Smith (*infra*) had identified small areas of axonal (nerve fibre) damage in the brain which he did not consider to have been contributory to the death. He had not found any ischaemic damage. Evidence of lack of oxygen (ie ischaemic changes) could sometimes be seen in the brain, but only if the deceased had survived for sufficient time to allow the changes to develop. In a suicidal hanging, for example, there would be no signs beyond the ligature mark. Fatal brain damage could be sustained, yet be undetectable. The person had to have survived for at least 35 minutes before the changes, such as those to the axons, would have occurred. If the changes found had played a part in the death, there would have to have been two separate incidents with a severe blow closer to death. There was no positive evidence of that, but it could not be excluded.
- [13] In answer to a somewhat leading question, Dr Turner agreed that the fractures, the bruising and the petechiae could be consistent with asphyxia. She had seen such findings in individuals who had died because of compression of the neck or ligature or manual strangulation. The pressure and/or the blows to the deceased's neck could have caused the death, but not necessarily so. The application of the scarf alone could account for the findings and for the death of an individual who had taken neither cocaine nor alcohol. There

was no evidence that the deceased had died from natural causes.

- [14] There were four mechanisms of death associated with the pressure or blows to the neck. The first was that the airways could have been blocked, so that no air reached the lungs. The second was that the blood vessels taking blood to the brain could have been blocked. The third was where there had been pressure to the carotid arteries, again causing a blockage in blood flow. An individual would become unconscious within 10 to 15 seconds after the application of constant pressure, but that pressure would require to be sustained for 4 or 5 minutes to cause death. The fourth was when pressure was applied to the carotid body (or sinus). This could cause a nerve reflex leading to heart arrhythmia. It was possible that the deceased had sustained trauma to cause the minor axonal damage, causing concussion or unconsciousness, before any pressure had been applied to the neck. If the deceased had been face down and bleeding, with a ligature around his neck, the compression would have continued and could have caused death.
- [15] An element of respiratory depression, from the combination of diazepam and buprenorphine, could not be excluded, but individuals could tolerate such levels as were found. Cocaine could be associated with cardiac arrhythmia. However, such arrhythmia tended to cause sudden collapse. This was not consistent with the deceased having been able to defend himself against an assault. In summary, the findings indicated pressure and/or blows to the neck which could have caused the death, but not necessarily so. Dr Turner agreed in cross-examination that she did not “definitely” know what had killed the deceased. There were three potential causes, but she could not “definitely” say which one, or combination, had killed him. The main factors were the head injuries, the injuries to the neck and the cocaine and alcohol intoxication. Alcohol and buprenorphine deaths followed progressive sleepiness and unconsciousness. Hypothermia was a very non specific finding. The deceased had been wearing a polo neck. Dr Turner would not have expected the deceased to have died of hypothermia without his being unconscious for some other reason.
- [16] Colin Smith, professor of neuropathology at Glasgow University, spoke to his report to the effect that there had been no significant ischaemic brain injury. Such injury might be seen if there had been a stroke or if the heart had stopped for some reason. Prof Smith did identify a “very small” number of damaged axons in one localised area. The underlying pathology for these would be, for example, a “good” bump to the head causing the person to see “stars”. It would involve a “very mild” form of head injury, usually caused by a twisting, or rotational, type of movement, such as might happen if a person walked into a door frame. The injury did not contribute to the death. According to the literature, it would require a survival time of about 35 minutes for damage to appear, although he “wouldn’t like to be too definitive about that, but certainly ... some ... relatively short survival period”. In the midst of being cross-examined about axonal injury, Prof Smith was asked if “oxygen starvation, or blood starvation to the brain would show any signs”. He replied: “It does show signs and in this case they were not present”. He was not asked anything further, such as how long it would take for such signs to develop, whether they would be present in every case and how

long after trauma the signs would remain detectable.

- [17] Dr Hazel Torrance, a forensic toxicologist, spoke to the fairly high level of alcohol in the deceased's system (241mgs per 100mls of blood; cf the driving limit of 50mgs). The concentration of cocaine (0.05mg/l of blood) did not mean very much, although it had been taken within a few hours of death. The Valium (0.71mg/l of blood) was at a therapeutic concentration. Buprenorphine was an opioid substitute which could operate as a respiratory depressant. It was at a therapeutic level (7ng/ml of blood). The cannabis metabolite was at a low concentration.
- [18] The deceased's blood was found on the appellant's feet and his right hand. Spots and stains were found in the appellant's flat, including the hallway and livingroom, suggesting that he had been assaulted there. Smearing indicated that the body had been dragged through blood on the landing. Crown case
- [19] The Crown case, as reflected in the speech to the jury, was that there was "an asphyxial component" to the death. The appellant had "with his hands or with that scarf, or a combination of both, put pressure on his neck causing asphyxia". It was: "reflected in the indictment, that the precise means are not known to the prosecutor; may never be known ... but the medical findings show ... that pressure by simple pressure or blows ... [was] applied to his neck such as to cause an asphyxial death". The Crown founded upon the petechiae, the fracture to the larynx and the scarf to demonstrate asphyxia, noting that the blunt force trauma to the face and the blows could have caused concussion or unconsciousness before the application of pressure to the neck. Charge to the Jury
- [20] The trial judge directed the jury, on the issue of causation, as follows: "Now ... before you could find the accused guilty of murder or culpable homicide, assuming, ... you find him guilty of assault, you would have to be satisfied there was a direct causal link between the ... assault and [the deceased's] death. You would have to find, before you could find a causal link, that but for the ... assault [the deceased] may not have died. Now the assault ... need not be the only cause of death, but it must be one of the causes. You would have to be satisfied that if there was an assault it contributed significantly to the death, otherwise there would be no causal link and the accused, even if he was guilty of an assault, would not be guilty of murder or culpable homicide. If you were satisfied that there was an assault and that it contributed materially to the death, you would have to consider whether the link between the two, the causal link ... was direct or indirect, because some acts might pass what we call the 'but for' test; in other words, the deceased would not have died but for the act, but they might be considered too remote in time or other circumstances to be direct causes. ... there must be a direct and compelling link between the assault ... and the death. If there was an assault, was that assault an operating cause and a substantial cause of the death, even if some other cause or causes were operative."

- [21] The trial judge gave the jury certain examples of what might be regarded as a direct, as distinct from an indirect, cause and the effect of intervening causes superseding an earlier assault. He reminded the jury that they had to be satisfied beyond reasonable doubt that the assault was a substantial, direct cause of death. He continued: “You will bear in mind, ... the evidence about other potential causes, the evidence from the toxicologist and so on, the evidence about drugs, ... for example buprenorphine, the evidence about the consumption of cocaine and alcohol, the evidence about the potential for ... hypothermia, the evidence from Dr Turner and the evidence from Prof Smith about the ... lack of any signs of oxygen or blood starvation.”
- [22] The trial judge repeated the need for the jury to consider the alternative explanations, before returning to the evidence of Prof Smith about the axonal injuries not having caused or contributed to the deceased’s death. He referred specifically to the question and answer (*supra*) asked of Prof Smith, relative to the identification of signs of oxygen or blood starvation and reminded the jury that the appellant had relied heavily on this.

Submissions

Appellant

- [23] The first ground of appeal was that there had been insufficient evidence to prove that the appellant had asphyxiated the deceased. A jury was not entitled to form its own opinion on the cause of death. The cause given in Dr Turner’s post mortem report had not been stated to be asphyxia. Prof Smith had told the court that any restriction of the flow of blood or oxygen to the brain would leave signs on the brain, but there had been no such signs. That evidence had not been challenged or made the subject of any criticism by the Crown. Although Dr Turner’s evidence was that the petechiae could represent asphyxia related to a ligature, she did not have the findings of Prof Smith at that time. His neuropathological findings were not within her area of expertise. Prof Smith had clarified Dr Turner’s reference to asphyxia by excluding it, given the absence of signs within the brain. Dr Turner’s evidence had dovetailed with that of Prof Smith. There had been other potential causes of death, including hypothermia, cocaine, and cocaine combined with alcohol and buprenorphine. There had been no evidence which would have allowed the jury to form a different view without them becoming investigative forensic scientists. It was only by forming an opinion contrary to the evidence on complex scientific matters that the jury could have determined that the cause of death had been asphyxia. *Cameron v HM Advocate* 2011 SCL 633 was distinguishable because of the post mortem efforts by the accused in that case.
- [24] The second ground was that the trial judge had failed adequately to direct the jury about the Crown case and, in particular, that the Crown required to establish that the cause of death had been asphyxiation caused by pressure or blows struck by the appellant. The jury ought to have been directed that, were they to reject Prof Smith’s evidence, sufficient evidence of asphyxia had to be found elsewhere, but that they could not indulge in forensic analysis or

interpretation of medical or scientific matters on their own. Where an innocent explanation for the death had been introduced, it was for the Crown to meet that explanation and for the judge to give the jury guidance upon it. Where the pathologist was unsure of the cause of death, what basis could the jury have for rejecting the alternative explanations? The advocate depute had effectively, or in reality, restricted the libel to one of causing the death by asphyxiation.

- [25] The third ground followed on from the previous grounds in relation to the reasonableness of the jury's verdict. In line with *Geddes v HM Advocate* 2015 JC 229 , if the jury had been given proper directions, they would have come to the view that murder had not been made out, although they could have convicted of culpable homicide. If there was a need to keep expert witnesses within the confines of their knowledge and experience (*Liehne v HM Advocate* 2011 SCCR 419 ; *Hainey v HM Advocate* 2014 JC 33), there could be no basis for permitting the jury to form their own contrary view. Crown
- [26] There had been a compelling, cogent body of evidence against the appellant. The starting point had been the admission by the appellant that he thought that he had "done ... in" the deceased. The amount of evidence required to provide corroboration of an admission depended upon the circumstances (*Greenshields v HM Advocate* 1989 SCCR 637 at 642; *Meredith v Lees* 1992 JC 127 at 130). It was necessary to look at the evidence as a whole (*Gage v HM Advocate*
- [2006] HCJAC 7 at para [75]). There was evidence of the argument between the appellant and the deceased, the location of the deceased's body, the blood pattern suggesting dragging on the landing, the deceased's blood on the appellant and the tight scarf.
- [27] It was accepted that Dr Turner had not been absolutely sure of the cause of death and that there were a number of potential causes. There was still evidence from which the jury could conclude that the cause of death had been asphyxia. These included the petechiae , the ligature mark, the bruising to the tongue and the fracture to the larynx. There was no evidence of a death from natural causes. The scarf was sufficiently tight to cause asphyxial problems. The bruising, fracture and petechiae were consistent with asphyxiation.
- [28] There was no obligation on the Crown to exclude every potential cause of death. The question was whether the case has been proved beyond reasonable doubt (*Cameron v HM Advocate* (*supra*) at para [40]). It was a matter for the jury to decide which of several possible explanations for the death they accepted (*Megrahi v HM Advocate* 2002 JC 99 ; *Fox v HM Advocate* 1998 JC 94). The jury had not been asked to undertake the role of an investigator, but to consider the evidence (*Younas v HM Advocate* 2015 JC 180 at paras [61] – [66]; *Smith v HM Advocate* 2008 SCCR 255 at para [15]).

- [29] Dr Turner had rejected cocaine induced arrhythmia as a likely cause on account of the defensive injuries indicating that the deceased had been able to react. The deceased did not die before the assault. Dr Turner stated that evidence of lack of oxygen could be seen in the brain, but the person needed to survive for a period of time before changes would appear. Prof Smith had not been asked how long ischaemic injuries would take to appear, although he was asked this in relation to axonal damage.
- [30] The issue of causal connection was for the jury to determine (Johnston v HM Advocate 2009 JC 227 at para [56]), the medical evidence being only one element (Geddes v HM Advocate 2015 JC 229 at paras [98] and [100]-[103]).
- [31] There had been no misdirection. The charge had been balanced and would have left the jury in little doubt as to the issues upon which they required to decide (Geddes (supra) at para [97]; Shepherd v HM Advocate 1996 SCCR 679). The judge had told the jury in particular that the assault did not need to be the sole cause of death, but it did need to be a contributing factor. He had said that there had to be a direct and compelling link between the assault and death. He had highlighted the alternatives and Prof Smith's evidence.
- [32] The verdict had not been an unreasonable one but based on a compelling circumstantial case. The test was a high one (King v HM Advocate 1999 JC 226 at 228-230; Geddes (supra) at paras [4] and [88]) and it had not been met (Harper v HM Advocate 2005 SCCR 245 at 261).
Decision
- [33] In Geddes v HM Advocate 2015 JC 229 , it was pointed out (LJC (Carloway) at para [98]) that there is a distinct risk that, where medical science is unable to provide a definitive cause of death, it swamps other important evidence bearing on that issue. In that case, as in this, the jury were entitled to take into account evidence of a non-medical nature in order to decide the question, which was for them to determine, of whether it had been proved beyond reasonable doubt that the death of the deceased had been caused by the appellant in the manner libelled. In that regard, the limits of the verdict open to the jury are not prescribed by the Crown speech but, so long as it remains unamended, the libel set out in the indictment (Johnston v HM Advocate 2009 JC 227, Lord Reed at para [39]). That is how the trial judge approached the case. The questions for the jury were whether the assault libelled in the indictment caused the death, whether by asphyxiation or otherwise, and whether that assault was murderous.
- [34] There was sufficient evidence from which the jury could conclude that asphyxia was an operative or significant cause of the death, notwithstanding that, from the scientific view of a pathologist, no definitive (ie conclusive) opinion could be expressed. The jury's task was to look at all the evidence, some of which would not be known to, or taken into account by, a pathologist, in reaching a practical decision on whether it had been proved beyond reasonable doubt that it had been the appellant's attack on the deceased that had caused his demise. Here, for example, when determining whether the appellant had killed the deceased, the jury had the evidence that: at or about the time of death there had been an

assault on the deceased by the appellant; a scarf was tied very tightly around the deceased's neck such that markings on the skin could be seen; and the appellant had admitted to a neighbour shortly after the incident that he had indeed killed the deceased. When that evidence was taken into account, along with that of Dr Turner to the effect that the medical findings were consistent with asphyxiation, the jury had been entitled to hold that that was indeed the cause of death and that the asphyxia had been brought about by the appellant.

- [35] The fact that Prof Smith, in answer to a particular question, stated that there can be signs that asphyxia had occurred, but that such signs were not present, is of little moment in circumstances in which he was not asked whether such signs were always present following asphyxia. Dr Turner's evidence was to the contrary, and vividly illustrated by her description of victims of hanging. The appellant contended that the finding of a "very small" number of damaged axons was indicative that the deceased must have survived some 35 minutes after the appellant's assault upon him. Therefore, it was argued, the deceased could not have died from asphyxia since, in that event, there would have been signs of ischaemic brain damage. This theory, which was before the jury, is, however, permeated with evidential flaws. First, there was no evidence at all that the axonal damage must have been caused in the course of the assault by the appellant. Rather, it would seem that it could have resulted from almost any kind of minor trauma sustained by the deceased, who was prone to such events, such as bumping into a door. Secondly, there was no evidence that the damage occurred at the time of any incident involving the appellant, as distinct from an episode occurring hours or perhaps even days beforehand. Thirdly, and in any event, there was no evidence of how the timing of axonal damage might gel with that of ischaemic injury in the context of this case, where the precise mechanism of the asphyxia, and the onset of consequent death, was unclear. Fourthly, the reality of the situation is that the non-medical evidence, when coupled with its consistency with a pathology of asphyxia, overrode the significance of any uncertainty caused by this aspect of the proof. The jury were entitled to exclude hypothermia as an operative cause of the death of a relatively young man wearing clothing and situated in a close, even in winter time. They were entitled to reject the idea of a combination of alcohol and particular drugs, where the alcohol level was not unusually high and that of the drugs low, or within therapeutic bounds. That effectively left the assault, and indeed asphyxia, as at least a significant contributor to the death. The no case to answer submission was correctly repelled.
- [36] In *Younas v HM Advocate* 2015 JC 180, the obligation on a trial judge was described (LJC (Carloway) at paras [58] and [67]-[68]) as involving the provision of a framework or "route to verdict" which a jury can follow and the existence of which would render any verdict understandable. What was needed was a "succinct, balanced review" of the central factual matters for the jury's determination (*Geddes v HM Advocate* (supra), LJC (Carloway) at para [97]). The trial judge gave the jury general directions regarding their function in relation to the evidence and explained the role of expert witnesses in assisting the jury to evaluate evidence bearing upon the facts in issue. The judge told the jury that they were not bound to accept the evidence of the expert witnesses. He provided the jury with a review of

the evidence led and with a framework or “route to verdict”. The issues raised by the defence were fully canvassed by the trial judge in his charge, and indeed by both the advocate depute and the solicitor advocate for the appellant at trial. The judge made it very clear to the jury that, in order to return a verdict of guilty of either murder or culpable homicide, they had to be satisfied that there was a “direct and compelling link between the assault ... and the death”. He described the link as requiring to be “an operating ... and a substantial cause of the death, even if some other cause or causes were operative”. In this critical area of causation, the directions were exemplary in their clarity and concision.

- [37] The test in relation to the unreasonableness of a jury’s verdict, as described in section 106(3)(b) of the Criminal Procedure (Scotland) Act 1995, is an objective and a high one (*Geddes v HM Advocate* (*supra*), LJC (Carloway) at paras [4] and [88]). It is only in the most exceptional of circumstances that an appeal on this ground will succeed (*Harris v HM Advocate* 2012 SCCR 234, Lord Bonomy at para [67]). A verdict will be quashed only if the court is satisfied that no reasonable jury could have been satisfied beyond reasonable doubt that the appellant was guilty (*King v HM Advocate* 1999 JC 226, LJG (Rodger) at 230). The determination of fact remains the province of the jury, even if there must be a base line of quality (*McDonald v HM Advocate* 2010 SCCR 619 , Lord Carloway at para [27]).
- [38] There was a cogent body of evidence to demonstrate that the deceased had been asphyxiated by the appellant. The testimony from the forensic pathologist, Dr Turner, about her findings on post mortem examination, together with the other evidence that the appellant had assaulted the deceased and admitted that he had killed him, when combined with the existence of a scarf tied tightly around the deceased’s neck, entitled the jury to return a verdict of guilty based upon asphyxiation. There were criticisms of the evidence which might and were made by the defence, but these were matters for the jury. It would nevertheless have been surprising, given the whole evidence, if the jury had returned a verdict other than one of murder or culpable homicide. Their decision that the appellant’s actions were murderous indicates that the jury were satisfied that the appellant had killed the deceased in the manner described by the advocate depute in her speech to the jury.
- [39] The appeal must accordingly be refused. BAILII: Copyright Policy | Disclaimers | Privacy Policy | Feedback | Donate to BAILII URL: [https://www.bailii.org/scot/cases/ScotHC/2016/\[2016\]HCJAC67.html](https://www.bailii.org/scot/cases/ScotHC/2016/[2016]HCJAC67.html)

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