Court of Magistrates (Malta)
As a Court of Criminal Judicature

Magistrate Dr. Donatella M. Frendo Dimech LL.D., Mag. Jur. (Int. Law)

Today the 9th day of December, 2019

Criminal Inquiry No: 298/2017

The Police
(Inspector Elton Taliana)

-vs-

Yulia Toteva, holder of Identity Card number 166178A

The Court,

Having seen the charges brought against the accused **Yulia Toteva** for having:

> On these islands on the 09th January, 2016, between twenty minutes to five and thirty-five minutes past five in the morning in Mount Carmel Hospital, Attard, through imprudence, carelessness, unskillfulness in her art or profession, or non-observance of regulations, caused the death of Richard Geoffrey Paxton.

Having seen the Attorney General's consent so that this case be tried summarily and having heard the accused declare that she has no objection that the case be so tried.

Having heard the accused declare that she does not object to the case being tried summarily by this Court.

Having heard witnesses.

Having seen all the acts and documents exhibited;

Having heard the prosecution and defence counsel make their submissions;

Preliminary Considerations

Whereas the statement released by the accused was exhibited without ever having been confirmed on oath by the Investigating Officer, and thus where the signatures appearing thereon and the identity of the person releasing the said statement remain unconfirmed, the Court is precluded from taking further cognisance thereof.

The statement released by the accused tendered to the forensic expert Dr. Mario Scerri was taken immediately after Nurse Balzan had identified her as the nurse in charge of monitoring the cameras at the time of Paxton's death, thereby transforming her status from that of witness to suspect. In fact Dr. Scerri in his report describes how after taking Balzan's version of events *"L-esponent ipproceda billi ha x-xhieda ta' Julia Toteva (Ara DOK.M.S.5)"*.[1] In these circumstances the accused was not afforded the right to consult a lawyer before releasing her statement in clear breach of her rights as enshrined in ***Directive 2013/48/EU of the European Parliament and of the Council of 22 October 2013 on the right of access to a lawyer in criminal proceedings*** transposed into Maltese law through Article 355AU(1) of the Criminal Code. Article 2.1 of the Directive provides:

[1] Fol.131

> This Directive applies to suspects or accused persons in criminal proceedings from the time when they are made aware by the competent authorities of a Member State, by official notification or otherwise, that they are suspected or accused of having committed a criminal offence, and irrespective of whether they are deprived of liberty.

Whilst article 3.2.a of the said Directive continues:

> 2. Suspects or accused persons shall have access to a lawyer without undue delay. In any event, suspects or accused persons shall have access to a lawyer from whichever of the following points in time is the earliest:
> (a) before they are questioned by the police or by another law enforcement or judicial authority.

Since the learned expert was acting upon instructions given to him by the inquiring magistrate, a judicial authority, the same reasoning extends to his questioning of Toteva. For the said reason Toteva's statement made under oath to the court appointed expert is being declared inadmissible.

The Facts

Considers,

Whereas **WPS198 Jennifer Caruana** testified how the Birkirkara Police Station received a report from Major Martin Callus from the Corradino Correctional Facilities (CCF), that an inmate, Richard Geoffrey Paxton, had committed suicide in the forensic ward of Mount Carmel Hospital.[2] On site she spoke to Prison Warden 130 Zammit who had been in the guards' station when at 5.30am a nurse, Paul Balzan, had asked him to open Cell 5 as the inmate was not responding to his calls. Once the cell was opened, they found Paxton standing with a nylon rope tied around his neck. Nurse Paul Balzan was also spoken to by the sergeant. He stated that he was in the guard room from where it was noticed on the cctv camera that Paxton was by the cell door and had not been moving. He went to check on him and called his name but Paxton did not respond. For this reason, he asked the guard to open the cell door and when they entered, they found the inmate standing with a nylon rope around his neck. Nurse Rakhil Noor stated that she was in the guards' station looking at the monitor and at one point it was noticed that only one foot was visible and thus they approached the cell to call him. When he did not

[2] Fol.12

answer the guards were asked to open the cell door. The accused and another nurse, Chioma Petra, gave the same version.[3]

WPS 198 explains *"Whilst I was on sight, I saw the CCTV, where I saw 13 to 14 minutes, it was noted that all the time,* ***one of his lower part of his leg, only one was visible, and all the time it was motionless****."*[4] Yulia Toteva was spoken to *a tempo vergine* and as with the other nurses who stated that they were in the guard room and upon noticing that he was not moving they went to call him from outside his cell. He failed to respond so the guards were asked to open the cell door.[5] The witness adds ***"He was suicidal and nurse Yulia Toteva, was supposed to be in charge, I mean in charge of him. He was under supervision"****.*[6] The sergeant confirms that the part of the cell where Paxton committed suicide was not visible from the cctv camera *"most of the room was covered, except the part of the door…[the recording] was in black and white, I, I could recognise them".*[7]

From the **Current Incident Report**[8] drawn up by WPS 198 it results that whilst the nurses were in the guard room, it was **the accused who was in charge of checking the monitors**. This contrasts with Dr. Scerri's findings that *"M' hux accettabbli li tlieta minnhom kienu fuq break fl- istess hin….fis-shift ta' bil- lejl kien hemm erbgha nurses u cioe` Julia Toteva, Rachel Noor, Petre Chiomo Voleani u Paul Balzan".*[9]

The Proces Verbal

A preliminary observation relates to the finding in the Proces-Verbal that Paxton was in Cell No.22.[10] All witnesses, as do the scene of the crime officers, indicate that Paxton was in Cell no. 5.[11] The reference to Number 22 was in fact the number of the camera installed in Cell 5.[12]

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[3] Fol.13-14
[4] Fol.14
[5] Ibid.
[6] Fol.14
[7] Fol.16
[8] **Dok. JC1** a fol. 18 et seq.
[9] Fol.148
[10] Fol.11
[11] **Dok. ED**: Scene of Crime Report a fol. 24 *et seq* and in particular vide fol.34.
[12] Fol.66 *"CCTV camera bin-numru tnejn u ghoxrin (22):* Rapport Dr. Martin Bajada, **Dok.MB.**

Profs. Marie There Camilleri and **Dr. Ali Safraz** concluded that *"The death of this middle-aged man is certified as being due to asphyxia caused by hanging".*[13]

Since the Proces-Verbal 397/16 *inter alia* contains the statements released by various persons who were on duty at the time Paxton committed suicide, which statements were released to Dr. Mario Scerri who was tasked by the Inquiring Magistrate to hear evidence on oath[14] on the day the incident was reported[15], the Court will proceed to consider the said statements. The statements released to the Inquiring Magistrate in February, 2016 will also be examined.

In the course of the inquiry an affidavit was presented by Paxton's psychiatric consultant, **Dr. Joseph Spiteri,** who later confirms same on oath.[16] From the said evidence and affidavit[17] it results that Paxton was admitted to the forensic unit on the 1st January, 2016: *"huwa nzamm go single room taht constant watch li kien beda fil-fatt fl-1 ta' Jannar, 2016 u baqa sejjer sad-9 ta' Jannar 2016…huwa wkoll inghata l-hwejjeg u luna blanket hekk kif provdut mill-isptar dawn tal-ahhar huma rezistenti ghal uzu divers jew alternattiv li jistghu jintuzaw is-soltu. Huwa namm Level 1. …Level 1 tfisser "constant watch via cctv when in single room. Constant watch at arms length when out of single room by nursing staff.". Minbarra hekk kien ordnat li jsiru tfittxijiet ta' spiss ghal xi hwejjeg mhux awtorizzati li jkunu fil-pusess ta' l-istess Paxton."*[18] This declaration assumes relevance later on when the Court considers the obtaining security circumstances within the forensic unit.

Spiteri continues *"Nikkonferma li **Paxton** kien taht constant watch bin- nurse u din ghandha l- monitor biex tara l- andament tieghu. Minhabba l- fatt li l-pazjenti f' din is- sala jistghu ikunu vjolenti, in- nurse ma tkunx at arms length mal- pazjent izda tkun qeghdha tosservah mill- monitor provdut mill- kamra tal-osservazzjoni vicin is- single room stess….. **Irrizulta illi Julia Toteva filfatt hadmet zewg shifts fuq xulxin u cioe` hadmet aktar minn 12- il siegha n fila**. Naf li f' dak iz- zmien il- monitors ma kienux sew fis- sens li ma tantx kienu*

[13] Fol.222
[14] Fol.22
[15] Fol.125 et seq. **Dok. MS**
[16] Fol.143
[17] **Dok.MS13** a fol.165-168
[18] Fol.167

cari u l- maggur ha action dwar dan il- kaz. Mistoqsi dwar il- bieb tac-cella nghid li dan m' ghandux ikun tali li l- pazjent ma jidhirx minn barra u ghalhekk ghandu jkollu vertical bars minn fuq s' isfel u ***ma jkollu l- ebda kwalita ta' rabta li tista tinqafel mieghu****. Dwar il- perspex fuq wara nghid li hemm bzonn isir xi haga ghax il- perspex jista' jkun ta' periklu ghall- pazjenti."*[19]

A document submitted by **Dr. Spiteri**[20] indicates clearly that on the night in question Yulia Toteva was working the night shift from 7pm of the 8th January, until 7am of the 9th January. Other nurses on the same shift were Nurses Balzan, Noor and Chioma Udeani. Toteva had worked also from 1pm until 7pm.

Joseph Mallia whose firm was responsible for installing the cameras in the unit, explained that the cameras installed at the forensic ward had been so installed since 2005 and at the time they were 'state of the art'. After the incident the cameras were substituted with colour cameras showing a wider angle.[21] Mallia denies ever have been informed that any of the previous cameras were not capturing the whole room nor did he receive any complaints.[22]

Correctional Officer 42 Joseph Mifsud explained how upon admittance to the Forensic Ward at around 6pm, together with fellow guards Degiorgio and Zerafa, Paxton was strip-searched, his cell door was locked and at 7.30pm pills were administered. His door was locked and together with C.O. Philip Zammit, they continued with their duty to watch the monitors. This duty *"Ta' bil-lejl inkunu tnejn. Nghid li l-monitors huma zghar bejn tlieta sa' erbgha pulzieri b'kollox u huma black and white. Taqla' ghajnejk biex tara xi haga u nzid nghid li l-kamra ta' Paxton lanqas taraha kollha. Fil-fatt il-bieb tal-kamra l-camera ma taqbdux……. hemm il-monitors tan-nurses imma huma zghar bhal taghna u mcajprin ukoll."*.[23] He goes on to describe the events leading to the discovery of Paxton. Balzan had gone to check on Paxton around 5:00-5:10 but did not mention anything to the guards[24]. They saw nothing untoward regarding Paxton until the time when he went to a part of cell 5 which wasn't captured by the cctv camera and

[19] Fol.144
[20] Fol.142; Vide **Dok.MS12** a fol. 164
[21] Fol.357
[22] Fol.358
[23] Fol.186 PV
[24] Ibid.

spent quite some time in the same place. *"Richard Paxton kien f'Cella wahdu peress illi diversi drabi kien ipprova jikkommetti suwicidju. Fil-fatt* ***suppost kien taht constant watch b'nurse mieghu kontinwu. Meta Paxton ikun fic-cella ma jkunx hemm nurse mieghu imma tkun ghassa tieghu minn fuq il-monitors tan-nurses.****"*[25]

Before Dr. Mario Scerri he explained what ***high level constant watch*** entailed: *"Illi lbierah fis-6:00 p.m. saret search fuq* ***Richard Geoffrey Paxton.*** *Ahna nahdmu l-Forensic Ward u f' dak il-hin* ***Paxton*** *iddahhal fic-cella. Nispjega li matul il-gurnata jkun barra flimkien mad-detenuti l-ohra u jkun liebes il-hwejjeg tieghu personali Hu kien high level constant watch jigifieri kellu nies mieghu l-hin kollu u cioe` ma jafdah f' xejn u anke jekk imur it-toilet imur mieghu. Nghid li fis-6:00 p.m. id-detenuti jiddahlu kollha fic-cella u fuq ftit minnhom issir search. Peress li* ***Paxton*** *kien bil-constant watch saret search fuqu. Jien kont prezenti ghal din is-search, flimkien ma Franklyn u De Giorgio. Nehha l- hwejjeg kollha u hadnihomlu u tajnieh il- hwejjeg taghna ta' MCH u cioe` Tee-shirt blu u boxer shorts u qalziet ta' taht. La t-Tee-shirt u lanqas is-shorts m'ghandhom bwiet. Nghid li dan ikkopera maghna. Nghid ukoll li saret search fil-kamra bhal ma jsir is-soltu u qallibna kullimkien inkluz taht is-saqqu. Nghid ukoll illi kellu luna blanket u anke din giet spezzjonata. Kollox deher illi kien sew u sakkarna l-kamra. Nghid illi fil- kamra tieghu hemm CCTV u ghalhekk il-movimenti kollha fil-kamra jigu rrikordjati.".*[26] He conducted the search on Paxton and his cell together with Franklyn Zerafa and Romeo Degiorgio. At 5.30am Nurse Paul requested him to open the cell door as Paxton wasn't talking to him.[27]

Correctional Officer 98 Romeo Degiorgio also mentions that Paxton was a patient who required close monitoring but was placed in a room unfit fit for such cases *"kien pazjent naqra jahraq, jigifieri kellu bzonn aktar attenzjoni minn ohrajn tant illi kien f'wahda minn tliet ikmamar intizi ghal dawn in-nies, ghalkemm nghid li mhux daqshekk attrezzati tajjeb ghal dan l-iskop.".* Degiorgio mentions how he largely focused on Paxton's person during the search.[28]He ended his shift at 7pm on the 8th after the said search.[29] Before Dr. Scerri he adds *"Qieghed nigi muri lenza bajda u nikkonferma li qatt ma rajt din il- lenza jew wahda bhalha. Huwa neza l-hwejjeg li kellu normali li*

[25] Fol.187
[26] Fol.126
[27] Fol.127
[28] Fol.188
[29] Fol.189

kellu fuqu u ahna hadniehom. Taht dawn il-hwejjeg kellu n-non-tearable tee-shirt u shorts u hallejnihomlu. Naf li fittixna tahthom. Qlibna s sodda u ma sibna xejn."[30]

Correctional Officer 59 Franklyn Zerafa who participated in the search on Cell 5 and on Paxton's person together with Degiorgio and Mifsud, states how after conducting the said search, a pillow was also removed from the cell. He finished his shift at 9pm on the 8th January.[31] Questioned whether he was aware of cavities which the mattress had in each of the four corners due to its design, he mentions that he did not;[32]nor was Joseph Mifsud aware of their existence.[33] In his statement to Dr. Scerri he is categorical *"Fis- search fil-kamra ma sibna xejn. Qieghed nigi muri lenza bajda u qieghed nikkonferma li qatt ma rajtha x' imkien."*[34]

Correctional Officer 130 Philip Zammit testified that he commenced his shift at 5pm and was on monitor duties from 3:00am of the 9th January onwards. Persons situated in rooms equipped with cctv cameras were Level 1 patitents ***"Li naf zgur min ikun f'dawn il-kmamar bis-CCTV ikun Level 1 u jkollu nurse ghassa mieghu kontinwu".*** Regarding Cell 5 he states *"hemm madwar zewg piedi minnha man-naha tal-bieb li ma jinqabdux. Fil-fatt il-bieb ma tarahx u anki t-tieqa ma tinqabadx kollha. It-tieqa fiha xi tmien piedi jew iktar u kull ma jinqabad xi zewg piedi u nofs jew tliet piedi minnha. Xi tliet ijiem qabel l-incident ta' Paxton kienu irrappurtaw dwar din il-camera partikolari u kien gie Joe Mallia biex jara x'jista' jsir. ….. Nghid li s-sistema li hemm ma tantx hija tajba u ma tantx tara sew ghaliex black and white."*[35]. He then goes on to describe what happened prior to discovering Paxton *"Ghall-habta ta' **4:45 a.m. jew 4:50 a.m.** tad-9 ta' Jannar 2016 indunajt li lil Richard Paxton ma kontx qed narah fuq il-Camera u mort hdejn ic-Cella, ittawwalt minn trapna zghira u staqsejtu hux kollox sew u qalli li kollox sew….. Ftit wara, daqs ghaxar minuti wara rajt nurse, Pawlu Balzan, sejjer lejn ic-Cella ta' Richard Paxton biex jiccekjah. Dak il-hin dan in-nurse ma giex hdejna. Imbaghad ghall-habta tal-5:30a.m. qalli biex niftahlu c-Cella ta' Richard Paxton ghaliex ma kellmux. Jiena mort mieghu u ftahtlu u x'hin dhalna sibnieh*

[30] Fol.136
[31] Fol.193
[32] Fol.194
[33] Fol.185 *"Ma nafx, ghaliex is-serach fuq is-saqqu m'ghamiltux jien"*
[34] Fol.137
[35] Fol.190-191

mghallaq."[36] To Dr. Scerri he had stated *"ghall-habta tal- 4:45 a.m. ma bdejtx narah sew mill- camera u mort u kellimtu minn wara l- bieb u staqsejtu jekk kienx kollox sew u hu rrisponda "yes". Ghall- habta tal-5:00 a.m. gie n-nurse Pawlu Balzan u qalli biex niftahlu c-cella ta' **Paxton** peress illi ma bediex ikellmu. Dhalna u sibnieh bil- wieqfa b' saqajh mal-art u kien imdendel b' lenza. Qatt ma rajt lenza bhal dik.".*[37]

The court notes that an alaysis of the foortage of Paxton's cell by two independent experts confirms that Paxton had hung himself by **04:42:43**[38] Whilst the footage shows Zammit checking on Paxton at 04:53:54 - 04:54:02,[39] over ten minutes after his demise and this when he could not have spoken to him as he contends!

Nurse Paul Balzan[40]stated before the Inquiring Magistrate that he was on duty between 6pm on the 8th January until 6am on the 9th. He stresses that Paxton was **on constant watch: "***Richard **Paxton kien qieghed taht "constant watch" li ahna nghidulu Level 1**. Huwa kien qieghed taht "constant watch" **peress illi kien qed jhedded li jaghmel "self harm".** Fuq "shift" ta' tnax-il siegha inkunu erba' nurses. Wiehed ikun qed jiehu hsieb ir-reporting u cioè johrog u jaghmel rapporti dwar dak li jigri waqt s-shift u t-**tlieta l-ohra jaqsmu t-tnax-il siegha bejniethom ghal dak li jirrigwarda l-"constant watch". Din il-watch issir billi jkun hemm nurse ghassa mill-monitors.** Ghalkemm suppost "constant watch" tkun "one to one", fis-sala taghna, jigifieri fil-Forensic Unit, hemm nurse wiehed jew wahda ghall-pazjenti kollha li jkunu taht "constant watch". Fi swali ohra f'Mount Carmel hemm sistema li jekk il-pazjenti taht "constant watch" ma jkunux one to one, jitla' t-tabib li jaghmel notament bil-miktub li jkun hemm lack of staff. Din is-sistema fis-sala taghna, u cioè fil-Forensic Unit, ma tapplikax, ikun hemm kemm ikun hemm persuni taht "constant watch" ikun hemm nurse wiehed biss. Sa fejn naf jiena r-raguni ghalfejn is-sistema kienet hekk hija li n-nurses li jahdmu fil-*

[36] Fol.Fol.191

[37] Fol.128

[38] Fol.244. Vide also Dr. Martin Bajada's report which corroborates this finding namely that the last sign of life shown by Paxton was at 04:42:57 (fol.67)

[39] Footage Camera 12

[40] Although the PV Report mentions a Paul Zerafa this is erroneous as evidenced by the transcript which clearly indicates that this testimony was that of Balzan, indicating the same identification particulars as those found in the Current Incident Report pertaining to Paul Balzan (Fol.19). This is further corroborated by the Roster exhibited by Dr. Spiteri (MS12 a fol. 164 in **Dok.MS**) and other colleagues who only mention Nurse Paul Balzan.

Forensic Unit huma mal-partikular u mhux mal-Gvern u nahdmu fuq sistema part-time u full time ghax imhalltin però kwazi hadd minna ma hu membru ta' xi Union u allura li jghidulna naghmlu jkollna naghmluh ghax tista' tghid m'ghandna sahha ta' xejn.".[41]

On the night in question he was on reporting duties. **Balzan identifies the accused as being on monitors duty at the time of the incident.** "*Dakinhar tas-shift bejn it-8 ta' Jannar 2016 u d-9 ta' Jannar 2016 jiena ma kontx ghassa "constant watch" izda kont reporting. In-nurses li kienu qed jiehdu hsieb il-"constant watch" kienu Rakhil Noor, Petra Chioma, Yulia Toteva u dawn qassmu l-lejl bejniethom. Nghid li Richard Paxton kien pjuttost perikoluz peress illi già darbtejn qabel kienu sabuh qed jipprova jikkommetti suwicidju. Darba sabuh qed jorbot lazz mat-tieqa li tigi ezatt quddiem il-camera u darb'ohra sabulu cintorin mitwi.* ***Ghall-habta tal-5:00 a.m. jew il-5:05 a.m. tad-9 ta' Jannar 2016 mort hdejn in-nurse li kienet ghassa mal-monitor biex nikteb xi reports u x'hin harist lejn il-monitor Richard Paxton ma kienx qed jidher u staqsejt lin-nurse Yulia Toteva fejn kien qieghed Paxton u hi qaltli qieghed wara l-hajt u cioè mal-hajt tal-bieb tac-Cella****, liema parti tac-Cella ma tinqabadx mill-monitor. Dak il-hin* ***ma kienetx tidher inkwetata però xi zewg minuti wara ddecidejt li mmur nittawwallu.*** *Fil-bieb kull ma hemm biex thares huwa opening zghir gholi ta' madwar zewg pulzieri u nofs. Ittawwalt fil-kamra li kienet mitfija u kien hemm id-dlam izda* ***peress li kien ma' genb il-bieb u l-kuridur kien mixghul, rajtlu l-genb ta' drieghu u serraht mohhi li vera qieghed hemm. Dak il-hin ma kellimtux*** *ghaliex naf li kien bniedem irritable u bhal speci ma ridtx nahsdu.* ***Jiena ma kontx naf kemm kien ilu f'din il-posizzjoni****. Jiena ergajt mort hdejn il-monitors u komplejt nikteb ir-reports u* ***wara xi kwarta bejni u bejn ruhi ghedt: "dan kemm ha jdum hemm."*** *Nghid li mhux l-ewwel darba li pazjenti joghqodu f'dik il-posizzjoni u cioè f'dik il-parti tal-kamra u gieli anki hadu s-saqqu hemm u raqdu. Jiena* ***allura ergajt mort nittawwallu u rajtlu idejh u din id-darba bdejt insejjahlu b'ismu xi tlieta jew erba' darbiet.*** *Peress illi hsibt li ma riedx jitkellem* ***dahhalt idi halli mmissu izda ma lhaqtx. Meta rajt hekk mort hdejn il-gwardjan biex jigi jiftahli*** *ghaliex Paxton ma riedx jirrispondini. Ahna ftahna u sibnieh mghallaq. …. Meta mort ghall-ossignu l-ewwel darba* ***ghajjat lin-nurses u gie kulhadd****. Bdejna naghamlulu s-CPR, cempilna lit-Tabib li qalilna biex nibqghu ghaddejjin bis-CPR sakemm tigi l-ambulanza.".*[42] Balzan adds that the accused was awake during the time he was writing his reports "*Il-monitors li naraw minn fuqhom huma zghar u mudlama hafna li bniedem lanqas taghraf wiccu. Fil-*

[41] Fol.201-202

[42] Fol.202-203

fatt minn dakinhar ta' l-incident ta' Paxton qed inhallu l-kmamar tal-pazjenti taht "constant watch" mixghula….. Ma fejn rabat il-habel Paxton fil-frame tal-bieb hemm toqba li facli tista' torbot xi haga maghha"[43].

When testifying before Dr. Mario Scerri on the day of the incident and, upon being shown the rope by which Paxton had hung himself with, similarly to CO Zammit, he states *"nikkonferma illi qatt ma rajt bhalu l-isptar."*[44] He goes on to describe what happened in the minutes leading to the discovery of Paxto's body *"Bil-lejl inkunu erbgha nurses. Xogholi huwa reporting u cioe` biex inzomm ir- records tal- pazjenti kollha. Ma' **Paxton** kien hemm nurses illi jaqsmu bejniethom il-hin biex il-hin kollu jaraw il- monitor. **Ghall- habta tal- 5:00 a.m. kellimt lin- nurses u x' hin mort hdejha u hrigt hdejn il- monitor u lil Paxton ma rajtux. Din jisimha Julia. Din qatli li kien mar il-hajt u cioe` f' post fejn il- monitor ma jaqbdux. Qaltli illi ftit qabel kienu dahlu jkellmuh minn wara l- bieb.** Jien mort nittawwallu u bdejt insejjahlu u meta rajt li ma rrispondiex, gejt ghand Philip il-gwardjan u tlabtu jiftahli. Dhalna u sibtu sospiz mill-ghonq b' lenza tixbah lil din li qieghed nigi muri b' dahru mal- hajt.".*[45]

Paul Balzan also testified *viva voce* and explained how on the night in question he wasn't assigned monitoring duties but was tasked with drawing up patients' reports. He went to write these reports on a table where the monitor was situated *"so, automatically I looked at the monitors and when I looked at the room where the patient was in, I did not see him."* He describes the difficulty which cell 5 was wrought with *"that particular cell, it wasn't visible on the monitors, it wasn't all visible. Part of it wasn't visible in the monitors. The side of the door was not visible. Even the monitors themselves, were very dark. …you could identify, but you have to look and look again, to make sure what you are seeing. So, when I looked at the monitors, I looked and I couldn't see the patient in the monitor"*[46]. Asked by the prosecuting officer who was the nurse in charge he replies ***"Yulia".***[47] *"**I asked her where the patient was and she told me he's against the wall, against the wall, where the monitor is uncovered, heq she told me he is against the wall…** .I asked on this particular patient because he was not visible on the monitors….the sides of the door, you cannot see it on the monitor…**She told me that he's against***

[43] Fol.203
[44] Fol.130
[45] Ibid.
[46] Fol.292-293
[47] Fol.293

the wall, where it was not covered by the monitors"[48]. Concerned he decided to go to Paxton's cell and he looked through the cell door's small opening *"I looked through the trapina and they saw his hands…and I thought mela its true, he's against the wall, cause I saw his hands, just a few distance from the trapina, and I went back to where I was…I just said he's in there quiet…I did not call him".*[49] However after more time lapsed *"I went back because he was still not visible, and then I called him, because a little b it of time passed since I was there, I called him, and when he did not answer, I went straight to the guard [Philip Zammit] to ask him, to come and open."*[50] Balzan has no knowledge of the accused's whereabouts when Paxton was found but together with Zammit they were the first persons to go into the cell. Questioned directly by the Court, as differently presided, as to who was on duty on the monitors between 4am and 5am he is categorical ***"Yulia …..at that time she was on her own. On her own…one person monitors the cells, the monitors"***[51]. There is a register where the person assigned duty on the monitors is recorded. [52]

Balzan reiterates that although initially he felt no cause for alarm, as he had been told by Yulia a couple of minutes earlier that Paxton was standing by the wall, he still felt he ought to check up on him: *"..then a little more time passed and still I couldn't see him on the monitor, I went to check again, but when I called him he did not t answer me."*[53] On cross-examination he confirmed that there were written rules regarding monitor duties and these could be obtained from the nursing officer. He confirms with no hint of uncertainty that it was the accused who was on duty on the monitors that day **"She was duty"** and this resulted from the register *"You have to follow the register".*[54]

Stephen Sultana, CEO of Mount Carmel Hospital, exhibited day procedures[55] in place at the time of the incident as well as the rules governing Level 1 supervision at the Forensic Unit.[56] These rules *inter alia*

[48] Fol.294-295
[49] Fol.296
[50] Fol.297
[51] Fol.299-300
[52] Fol.300
[53] Fol.302
[54] Fol.305
[55] Fol.309
[56] **Dok.SS1** a fol.312

provide ***"A NURSE SHOULD ALWAYS BE PRESENT NEAR THE MONITORS ACCORDING TO THE ASSIGNED TIME AND THE NAME AND SIGNATURE MARKED CLEARLY ON THE CCTV REGISTER"*** These rules also provide that Level 1 means "*Constant watch via CCTV when in single room (SR)…the level 1 ….are to be covered by the one nurse currently covering the level 1 supervision when the patients are in the SR…The CCTV level supervision register should be filed as per current protocol."*[57] New rules introduced in March, 2017, aim to address the operational deficiencies which this incident undoubtedly caused to surface.[58] On cross-examination Sultana confirms that level 1 supervision meant **constant monitoring** through a monitor,[59] *"person to person"* as in other divisions at Mount Carmel Hospital *"At the Forensic he is being monitored just the same but through a monitor….at constant watch you have to supervise at all costs….and observe the patient."*[60]

The Footage

Dr. Martin Bajada describes how he examined the footage from Camera No.22 which was located in Paxton's cell concluding that **the last proof of life from Paxton was at <u>04:42:38 with Paxton hanging himself at 04:42:57</u>**. Upon viewing the footage the Court also confirms the said findings.[61] From the footage exhibited it results that a man approached Paxton's cell the time was at **04:53:54 -04:54:02.**[62] From evidence gathered in the course of these proceedings it results that this man was **Philip Zammit.** From **05:07:57 until 05:08:46** another person appears and this time he spends a longer period of time looking into the cell. This is a different person than the one seen previously as his build and attire clearly demonstrate.[63] Evidence shows that this was **Nurse Paul Balzan**.

[57] Fol.313
[58] Fol.325-334
[59] Fol.344-345
[60] Fol.345
[61] **DokMB1** a fol. 69
[62] Footage Camera 12
[63] Camera 12

Donald Tabone[64] who was given a copy of the footage already passed on to Dr. Bajada on the 9th January, 2016,[65] also confirms that at **04:42:43** Paxton made no further movements with **his last movements being recorded precisely at 04:42:03-24**.[66]He also makes reference to this second male person, Balzan, visiting the cell at **05:07:58 until 05:08:48**[67] who again is seen looking through the cell with a torch at 05:31:54 until 05:33:43.[68]

Footage from camera 12 which is best placed to show the activity outside cell 5 and which was carefully examined by the Court and wherein Tabone's time-line of events is hereby confirmed, shows **a nurse – not the accused** - approaching cell 5 at **04:04:08**. At 04:18-04:20:05 a cat is seen strolling in the corridor and at **04:25:07-41**[69] **the same nurse not being the accused** is seen looking through the cell door and passing something to the inmate. The next movement occurs at **04:53:54** when Zammit approaches the cell and looks through. He leaves at 04:54:01. Zammit explains that ten minutes later he saw Balzan going to check on Paxton and in fact footage shows Balzan checking in on Paxton between **05:07-05:08**.[70]

Yet when testifying Toteva states that she physically checked on Paxton around 4:30am "*The last time when I check and I spoke with him it was five minutes after 4.30, I am not sure exactly. One of the prisoners pressed the buzzer asking for coffee in cell 2. I went to give him coffee and on my way out I turned my head and I saw him staying behind the door….. I just ask him, everything is ok Richard? He told me yes…. After 4.30, it was after, I am not sure.".*[71]

Examination of the footage from 04:04 until 04:42 Paxton's time of death, reveals that the only person approaching his cell was a nurse other than the accused and she attends to Paxton on two occasions at 4:04 and 4:25!! **Toteva is nowhere to be seen thus contradicting her account of events** when testifying before this Court that she approached Paxton's cell sometime after 4:30am and he actually told her he was "ok"! The same

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[64] **Dok.DT** a fol. 236 et seq.
[65] Vide evidence **CO163 Johan Carter** a fol. 232-233
[66] Fol.244
[67] Vide stills a fol. 248-250
[68] Fol.242. Vide also Footage from camera 12 and Stills a fol. 251-255
[69] Fol.242
[70] Vide also fol.242
[71] Fol.390-391

footage contradicts findings that the accused was the only nurse tasked with overseeing patients' needs whilst also tending to the monitors![72]

These times tally with the version of events given by Paul Balzan as to when he visited Paxton's cell. **The said times indicate that between the suicide at 04:42:43 and his being discovered at 05:31:54, a period of forty-eight (48) minutes had lapsed!**

In his conclusions and after hearing a number of witnesses as so tasked by the Inquiring Magistrate, **Dr. Mario Scerri** points out that Paxton suffered from post-traumatic stress disorder and due to suicidal thoughts was kept in a single room under **constant watch which entailed that he was monitored at all times by a *CCTV*** *"u barra s- single room constant watch tkun at arms length mill- istaff tan- nurses"*. The nurses' night shift began at 7pm and lasted until 7am of the following day.[73] Their duty was to monitor inmates in single rooms. The parchment-like abrasion found on Paxton's body was compatible to the texture of the rope, "lenza", Paxton was found suspended with.[74]

Dr. Scerri amplifies on his findings *"Illi jirrizulta illi **Julia Toteva li kienet nurse fis-shift ta' bil-lejl** kellha tahdem shift iehor qabel ghar-raguni illi din giet ikkuntatjata mill-kumpanija li thaddimha fejn giet mitluba tidhol shift extra peress illi kien hemm nurse illi ma kienx sejjer jahdem u ghalhekk **spicat tahdem min-nhar it-8 ta' Jannar 2016 mis-1:00 p.m. sas-7:00 p.m. u mbaghad hadmet is-shift taghha mis-7:00 p.m. u kellha tispicca fis-9:00 a.m. ta' nhar id-9 ta' Jannar**;……*

Illi l- esponent ma jistax jifhem kif fil-hin li deheru li l- affarijiet ma bdewx sejrin sew, kien hemm biss nurse wahda tissorvelja l-monitors u cioe` Julia Toteva meta l-compliment tan-nurses kien ta' 4. M' hux accettabbli li tlieta minnhom kienu fuq break fl-istess hin; Illi din xogholha ma kienx biss tosserva l-monitors izda wkoll tattendi ghal htigiejiet ta' pazjenti ohrajn kif fil-fatt ghamlet u ghalhekk waqt li din tkun qieghda taqdi l-htigijiet ta' pazjenti ohra ma tkunx tista tlahhaq mal-monitors ukoll, meta dan seta' gie aktar iffacilitat ghaliex fis-shift ta' bil- lejl kien hemm erbgha nurses u cioe` Julia Toteva, Rachel Noor, Petre Chiomo Voleani u Paul Balzan".

[72] Fol.350
[73] Fol.146 of **Dok.MS**
[74] Fol.150

In this respect the Court must underline that nowhere does it result that the other nurses were on break. Balzan was writing reports whilst footage shows a nurse tending to Paxton twice at 4:04 and 4:25! Similarly nowhere does it result that besides doing monitoring duties the accused was tending to other patients and in fact this point has been emphasized by the CEO of Mount Carmel Hospital ***"....at constant watch you have to supervise at all costs....and observe the patient."***[75]and by the deputy charge nurse Alistair Chetcuti: ***"Nothing else****, just if I is her time to watch the monitor, it is* ***only watching the monitor".***[76]

Scerri's conclusions continue: *Illi mill-filmat li gie mghoddi lill-esponent minn Dr. Martin Bajada, jidher illi sa qabel l-4:41 a.m.* ***Paxton*** *kien qieghed jidher fil-kamra u anke jdur izda kien* ***hemm perjodu twil bejn l-4:41 a.m. u l-5:34 a.m. illi dan ma deherx. Dan kien definittivament hin twil fejn Paxton ma' deherx u hadd ma nduna****;..."*[77].

When testifying *viva voce* **Dr. Mario Scerri** whilst confirming the report presented in the course of the magisterial inquiry, highlights a number of factors which in his opinion contributed to the incident. Level 1 supervision meant close contact with the patient through a monitor which monitors *"were barely visible…they weren't clear, the cameras weren't clear and the positioning of the camera is not good …the area behind the door…is totally not captured…it is a farce".* [78]Although on the night in question there were supposed to be 4 nurses on duty *"but during the hours when all this happened, there was a time-frame of about an hour when the accused was the only person monitoring the monitors and monitoring the patients' needs"*[79]*;* the other nurses were *"nowhere to be found".*[80]

The Court has already remarked that **no evidence was tendered to justify this finding.** To the contrary two nurses were carrying out their respective duties at the time of the incident, the nurse appearing on the footage and Balzan who had he not been near the monitors writing reports, Paxton's absence from the camera's vision would have gone unnoticed by the nurses!!

[75] Fol.345
[76] Fol.412
[77] Fol.147-148
[78] Fol.349
[79] Ibid
[80] Fol.350

Another conclusion which this Court, upon evaluating the evidence before it, cannot share is the expert's assertion that owing to the lack of visibility the monitors were wrought with, the accused *"might have been misled by thinking he was on the bed….She might have taken the impression that there is a motionless person on the bed".*[81]

This assertion is clearly contradicted by the testimony of **Nurse Paul Balzan who upon glancing at the monitor immediately realized that Paxton was out of vision!** This is what compelled him to become concerned for his safety and confer with Toteva. Unlike Balzan, Toteva took no further action to ensure Paxton's well-being, at least by asking him to remain in sight of the camera or talking to him over the intercom! **Knowing too well the deficiencies of the cctv system already highlighted coupled to the fact that Paxton was a high risk patient who had already attempted to commit suicide, Toteva ought to have exercised more diligence in ascertaining Paxton's well-being by physically ensuring he was in no manner endangering himself. Once he remained no longer visible on the monitor it was her duty to ensure he was safe at all times whilst out of view.** Instead ***"hemm perjodu twil bejn l-4:41 a.m. u l-5:34 a.m. illi dan ma deherx. Dan kien definittivament hin twil fejn Paxton ma' deherx u hadd ma nduna;.."***[82]. Contrary to Toteva both Zammit and Balzan realized that Paxton was not visible and took action albeit a tardy one.

Yulia Toteva chose to testify and explained what her duties at the forensic unit entailed. Her job was to administer treatment, prepare documentation and observe level 1 patients. She had started work at 1pm on the 8th January, 2016 finishing at 7am the next morning, a total of 18 hours.[83] She had been assigned to watch the monitors from 7pm until 9pm and from **1am-3am** and when she was not observing level 1 patients she had to tend to other patients' needs. Level 1 meant observing the patient through a monitor *"When I sign that I am with him, I watch only him."* changing after two hours.[84] *"The monitor was small, black and white, blurred, you cannot see properly the prisoner inside."*[85] She contends – although failing

[81] Fol.353
[82] Per Dr. Mario Scerri a fol.147-148
[83] Fol.383
[84] Fol.384-385
[85] Fol.385

to substantiate this version of events by any evidence – that she was supposed to break between 3am and 4am but she did not take her break as no-one came to replace her. After 3am she was supposed to be replaced on the monitor watch by nurse Rakel Noora (Noor)[86] Nor is this proven even remotely by the accused!

She explains that there were supposed to be two nurses watching the monitors so that whilst one tends to the monitors the other tends to patients' needs. Both nurses normally stay in the monitor room instead of going to the nurses' station since the patients continuously buzz the nurses for a variety of reasons and thus they remain close by in case they don't hear the buzzer.[87] She describes the monitor as one having different screens showing different parts of the ward *"It was small, black and white, blurred, we cannot see properly the prisoners inside, even if the light is on."*.[88] She describes the blurriness as a grainy image and explained that she complained about the poor quality on several occasions,[89] last complaining a week before the incident.[90]

***Court**: Ok, now since that the visual is not good enough, did you ever feel that you should go yourself to check with your own eyes?*
***Yulia Toteva**: I did it*
***Court**: You did it*
***Yulia Toteva**: And we have another thing in the monitor room, we have buzzer, from which buzzer not only prisoners can speak with us, we can speak also by pressing the buzzer, if I see something wrong, I will press and I will ask everything is ok? And he used to answer me yes I am ok, he doesn't need to go to the buzzer in the cell to answer me because he can hear me in each part of the room my voice. And I can hear him.*
***Court**; Ok, that day, that night before his death, had you gone to see?*
***Yulia Toteva**: Yes.*
***Court**: What time did you go last to check and why you feel you had to go?*

The accused then goes on to make a statement which is completely belied and contradicted by the footage:

[86] Fol.386
[87] Fol.386
[88] Fol.387
[89] Fol.388
[90] Fol.389

***Yulia Toteva**: The last time when I check and I spoke with him it was five minutes after 4.30, I am not sure exactly. One of the prisoners pressed the buzzer asking for coffee in cell 2. I went to give him coffee and on my way out I turned my head and I saw him staying behind the door, and as the distance is three metres, three or four metres between this cell 2 and his cell, I just ask him, everything is ok Richard? He told me yes.*
***Court**: 3 to 4 metres between his cell and what?*
***Yulia Toteva**: And the other cell to which cell I went to give the coffee.*
***Court**: So that was the last time you spoke to him 4.30?*
***Yulia Toteva**: After 4.30, it was after, I am not sure.*[91]

She continues that around 4.30 she lit Paxton's cigarette. This too is contradicted by the footage**. She went nowhere near Paxton's cell from 04:04 onwards**. At around 4.50am she saw guard Philip checking upon Paxton. Paul Balzan also checked up on him after 5am. She could see this as she was in the monitor room. Balzan and Philip told her that Paxton was ok. At the time Paxton was supposed to be watched by 4 persons, two guards and two nurses.[92]

Regarding the cctv register she claims that she realised it had been tampered with before she was interrogated by the police. She as far as accusing nurse Balzan of having overwritten her name. She explains that the first entry should have had her name indicated on the 7-9pm shift, but instead the name Rakel Noor was written over it. She states that she confronted Balzan about this *"He told me I don't know, I was afraid, that what his words where"*.[93] Referring to the initial writings in the cctv register she adds *"here is written 1-3, that is my handwriting which I see it now. That is my signature in front of my name, the others is not my handwriting, even is not my signature. I did not sign it."*.[94]

Asked by the court why she did not inform the police that the register had been tampered with, she replied that she wanted the police to investigate the matter! **Yet if this was so, why did she feel the need to confront Balzan?**

[91] Fol.390-391
[92] Fol.394
[93] Fol.397
[94] Fol.397

To the court's question, Toteva strangely replies that at the time she was confused and excited thereby failing also to inform the inquiring magistrate. However, the inquiring magistrate spoke to Toteva a month later in February, 2016, and still the accused chose not to disclose such a disconcerting fact which could have exonerated her completely from any responsibility!!

The Court finds such version of events as recounted by the accused illogical and begging of common sense given that a person who realises he is being framed would immediately make mention of the fact in a bid to safeguard his innocence and an immediate reaction to one's innate sense of self-preservation! Moreover, she confirms that after things had calmed down, she still failed to file a police report regarding the matter.[95]

Toteva mentions how following the incident a number of changes were carried out in the forensic unit to address the deficiencies hitherto existing.[96] She ends her testimony recounting that a bad argument had taken place with Balzan and Noor since they were sleeping on the job even when tasked with monitor duties, *"They dare to sleep even when they are with monitors and I could not feel safety anymore with them. That is why I moved…. To change the shift not to work with them"*.[97] However an inspection of the register, Dok.ETZ,[98] shows her still working same shifts both with Balzan on different occasions until November 2016, thus disproving also such a statement.

On cross-examination she confirms that Balzan and Zammit had informed her that Paxton was ok when, by her own account, Noor was on the monitors and not herself. Asked to explain this anomaly of having the guards inform her and not Noor, she simply states that it was because she was caring after her patients. She then goes on to admit that changes were indeed effected on the cctv register since she agreed with nurse Chioma *"we change each other from the beginning of the shift"*. This corroborates what Chetcuti states namely that Balzan had accounted for the changes in the register following changes in the nurses' shifts.

[95] Fol.399
[96] Fol.400
[97] Fol.401-402
[98] Fol.364

The Court does not find the accused's account a credible one. Instead it is wrought with inconsistencies and contradicted by other evidence. Her allegations remain unproven. Not a single shred of evidence was brought to substantiate same, thus proving her account on a basis of probability.

The CCTV Register

Dr. Martin Bajada was tasked by this Court to examine the CCTV monitors register[99] after it appeared *ictu oculi* that entries relating to nurses assigned to monitor duties on the date of the incident appeared written over.[100] The report[101] clearly evidences that, commencing with the entries of the 8th January at 9pm, changes had been made to the register in so far as the names of the designated nurses were concerned. Initially the shift between 1m and 3am was to be carried out by the accused and the one between 3am-5am by nurse Nooza (Noor/Noora).[102] However for some reason changes were effected and nurse Chioma is indicated as covering the 1-3am shift and the accused the 3-5am shift.[103] Whilst the names were overwritten with white tape the initials were not.

Alistair Chetcuti, at the time of the incident deputy charge nurse at the forensic unit, claims that two (2) nurses were supposed to supervise level 1 patients. Upon seeing the cctv register and the over written names he states that he was informed by nurses Balzan, Noor and Chioma that these changes had been effected *"cause there were changes in breaks everything[104]….they told me that they had to change the time due to ward exigencies".[105]* The nurse drawing up the report, which in this case was Balzan, verified the timings and he would have the nurses state the time in front of the cameras.[106] He confirms that **whilst Toteva was overseeing the monitors she had no other tasks to perform thereby concentrating only on the monitors** ***"Nothing else****, just if I is her time to watch the monitor,*

[99] **Dok.ETZ** a fol. 364
[100] Fol.360
[101] **Dok.MBZ** a fol. 370 *et seq*
[102] **Dok.ET2(B)** a fol. 377
[103] **Dok.ET2(A)** a fol.376
[104] Fol.410
[105] Fol.415
[106] Fol.411

it is only watching the monitor".[107] When not watching monitors the nurse would still be on duty attending to patients' needs. He describes the accused as *"a hard worker, she is one of the best"* [108]. He recalls the accused complaining about the monitor.

The register shows other occasions where entries were overwritten.[109]

Notwithstanding the reasons for such changes it remains an undeniable fact that **at the time of the incident it was only Toteva who was charged with Paxton's constant watch since she was at the monitors desk.** This is confirmed time and time again by Nurse Paul Balzan. As such the significance of these changes have no bearing on the merits of this case. Balzan declared: "***staqsejt lin-nurse Yulia Toteva fejn kien qieghed Paxton u hi qaltli qieghed wara l-hajt*** *u cioè mal-hajt tal-bieb tac-Cella, liema parti tac-Cella ma tinqabadx mill-monitor. Dak il-hin* ***ma kienetx tidher inkwetata*** *però xi zewg minuti wara ddecidejt li mmur nittawwallu. "*[110]

The accused's efforts at attacking Balzan's credibility by alleging that there had been a fall-out with him, remain totally uncorroborated. To the contrary Balzan did not hold back from pointing out the deficiencies of the system, the inadequacy of the monitors, the unfitness of the cell and the fact that the camera did not capture the whole room; factors which made the accused's monitoring duties all the more difficult. It is unfair on the accused's part to make unfounded accusations against Balzan that he tampered with the register to lay the blame on her. A shameful act to say the least given that his testimony was fair, balanced and contrary to her version of events, corroborated by other evidence!! The Court has no qualms in judging Balzan's versions as safe and satisfactory.

Having reviewed the evidence before it the court shall proceed to summarise the salient findings.

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[107] Fol.412
[108] Fol.413
[109] Vide entry for 12.01.2016
[110] Fol.7

Salient Findings:

1. Footage clearly shows that Paxton went out of view at **04:38:28**.[111]

2. His time of death was at **04:42**.

3. Paxton's body was discovered at 05:31:54; thereby there was a lapse of **forty-eight (48) minutes** between the time he went out of sight until he was found.

4. There was a lapse of **4 minutes circa** within which time, commencing from retreating from the camera's views, he committed suicide.

   Admittedly a very short time-span but one which was sufficiently long for Paxton to carry out his suicidal plans. It is unfortunate that it was only Balzan and Zammit that became concerned and physically checked up on him, little realizing that the inmate was already dead. Meanwhile Toteva remained **unperturbed** notwithstanding that Paxton was out of sight for such a lengthy period of time. When the alarm was raised it was not by Toteva but by Nurse Balzan!

5. Balzan stated also *"Richard Paxton kien pjuttost perikoluz peress illi **già darbtejn qabel kienu sabuh qed jipprova jikkommetti suwicidju**. Darba sabuh qed jorbot lazz mat-tieqa li tigi ezatt quddiem il-camera u darb'ohra sabulu cintorin mitwi".*[112]

6. There is no doubt that **it was the accused who was entrusted with Paxton's constant watch at the time of the incident**. Knowing of his suicidal tendencies, fully aware that the side of the cell to where he had retreated was not captured on camera, she should either have told him to move away to a part which was visible and captured on the cctv, or made an effort to continue talking to him until she was certain he was out of harm's way. She could also have asked colleagues or the guards to physically check upon him given that she could not move away from the monitor desk. Instead it was

[111] Fol. 244
[112] Fol.202

Balzan, who although not being the person responsible for Paxton's constant monitoring, became concerned, asked Toteva after him and still apprehensive upon realizing that the inmate still remained out of sight, took the initiative to physically check up on him.

Various testimonies prove that it was the accused who was tasked with Paxton's constant watch when this tragic incident happened.

Balzan testifies: ***Ghall-habta tal-5:00 a.m. jew il-5:05 a.m. tad-9 ta' Jannar 2016 mort hdejn in-nurse li kienet ghassa mal-monitor biex nikteb xi reports u x'hin harist lejn il-monitor Richard Paxton ma kienx qed jidher u staqsejt lin-nurse Yulia Toteva fejn kien qieghed Paxton u hi qaltli qieghed wara l-hajt u cioè mal-hajt tal-bieb tac-Cella****, liema parti tac-Cella ma tinqabadx mill-monitor".*[113] *A tempo vergine* to the Court expert he had stated ***"Ghall- habta tal- 5:00 a.m. kellimt lin- nurses u x' hin mort hdejha u hrigt hdejn il- monitor u lil Paxton ma rajtux. Din jisimha Julia. Din qatli li kien mar il-hajt"***.[114] Before this Court when asked by the prosecuting officer who was the nurse in charge of the monitors at the time of the incident he replies**: *"Yulia"*[115]*…. "I asked her where the patient was and she told me he's against the wall, against the wall, where the monitor is uncovered, heq she told me he is against the wall….I asked on this particular patient because he was not visible on the monitors….the sides of the door, you cannot see it on the monitor…She told me that he's against the wall, where it was not covered by the monitors.*[116]*……"Yulia…at that time, she was on her own. On her own…one person monitors the cells****, the monitors".*[117]

WPS198 who carried out preliminary investeihations also stated ***"He was suicidal and nurse Yulia Toteva, was supposed to be in charge, I mean in charge of him. He was under supervision"****.*[118]

7. Whilst this fact, namely that Toteva was in charge of monitoring duties at the time of the incident, is established beyond certainty, so

[113] Fol.202-203
[114] Fol.
[115] Fol.293
[116] Fol.294-295
[117] Fol.299-300
[118] Fol.14

are a multitude of factors which to the same extent undoubtedly played a significant part in the ensuing tragedy. Learned defence counsel cites but a few of these in the course of final submissions.

The misfortune in this case rests on the fact that it was not merely the accused who was negligent. Whilst Nurse Balzan's actions are commendable in that he saw it fit to check up on Paxton, sometime after 5am when he had already been out of vision for some time, it is rather disturbing that he failed to notice that Paxton had already hung himself.

These proceedings bring to the fore a case showing a division, the Forensic Unit within Mount Carmel Hospital, which although housed within a hospital, is run and operated separately and distinctly from the said hospital. The incident showed that in the running of the unit, the negligence was not solely that of the accused.

(a) The 'Search'

It has been established that during the day Paxton was allowed to mingle with other prisoners. Given his suicidal tendencies it became imperative to ensure that nothing in his room or on his person could lead to his self-harm. Yet the rope, 'lenza', found its way to Paxton when according to Dr. Spiteri "*Constant watch at arm's length when out of single room by nursing staff….. Minbarra hekk kien ordnat li jsiru tfittxijiet ta' spiss ghal xi hwejjeg mhux awtorizzati li jkunu fil-pusess ta' l-istess Paxton."*[119] Images of the rope can be seen in the same report compiled by the scene of crime officers.[120]

Needless to say the fact that a high risk patient, meant to be kept under constant watch at arms' length, is allowed to come into possession of the rope and take it to his cell, is appalling and disgraceful, revealing lack of expertise of those called to safe-guard the inmates' well-being; undermining all efforts by the authorities

[119] Fol.167

[120] **Dok.ED** a fol. 48-49

to afford safe and secure environment for inmates in need of psychiatric care.

Guard Zerafa states*: "Fis-search fil-kamra ma sibna xejn. Qieghed nigi muri lenza bajda u qieghed nikkonferma li qatt ma rajtha x' imkien."*[121]*;* Guard Zammit declares *"Qatt ma rajt lenza bhal dik."*[122] whilst Nurse Balzan confirms *"qatt ma rajt bhalu l-isptar."*[123] On his part Guard Degiorgio remarks *"Qieghed nigi muri lenza bajda u nikkonferma li qatt ma rajt din il-lenza jew wahda bhalha. Huwa neza l-hwejjeg li kellu normali li kellu fuqu u ahna hadniehom. Taht dawn il-hwejjeg kellu n-non-tearable tee-shirt u shorts u hallejnihomlu. Naf li fittixna tahthom. Qlibna s-sodda u ma sibna xejn."*.[124]

It is disturbing to learn that despite the various searches that guards were expected to carried out routinely on Paxton's cell, including the mattress, none of them thought it fit to examine it thoroughly. The guards were oblivious to the fact that the mattress contained four cavities at each of its corners thus rendering futile any search conducted in his cell; Zerafa,[125] Degiorgio[126] and Mifsud[127] who carried out the last search on Paxton all declare that they never noticed the said cavities, cavities which are clearly visible in the photographs depicted in the scene of crime report.[128]

The mere fact that such high-risk inmates were given such mattresses is for want of better definition perplexing at best.

How apt and justified are Dr. Scerri's remarks:*"Illi l-lenza li biha ssospenda ruhu Paxton tabilhaqq kienet mohbija fic-cella u ghalhekk wiehed jistaqsi dwar it-tip ta' tfittxija li saret fic-cella ta' Paxton nhar it- 8 ta' Jannar 2016 ghall-habta tas-6.00 p.m"*[129].

[121] Fol.137
[122] Fol.128
[123] Fol.130
[124] Fol.136
[125] Fol.6
[126] Fol.4 *"l-iktar li ffukajt fuqu"*
[127] Fol.2
[128] Fol.56-61; **Dok.ED**
[129] Fol.149

Nor can the court ignore that which was confirmed on oath by Joshua Caruana. This inmate had testified before the court expert, that he had been informed by a certain Martin that he had passed the rope to Paxton: *"Dan tahielu l-bierah u dan qalu Martin. Tahielu minn fejn is-single rooms. Naf li ta wahda lilu u l-ohra lis-Sirjan li ma nafx x' jismu. Il-bierah ghall-habta tad-9:00 p.m. Martin sejjahli u qalli li llejla kont sejjer nara show. Ma qallix x' kien dan is-show. Illum Martin beda jiftahar li lil* ***Richard*** *u lis-Sirjan tahom il-lazz huwa stess.".*[130] When questioned Martin Xuereb denied these facts.[131]

It is not for this court to enter into the merits of these allegations although it would be amiss if mention is not made of the fact that such an allegation, if proven, could tantamount to the crime of incitement or assistance to commit suicide sanctioned by article 213 of the Criminal Code.

(b) The Cell

Instead of providing the inmate with a safe and secure environment the cell proved to be Paxton's execution chamber!

Images from the scene of crime officers' report disticinctly shows this perilous opening in the cell door's frame,[132] *"giet indikata minn CO130 Philip Zammit toqba fuq in-naha ta' gewwa tac-caccis tal-bieb tac-cella nkwistjoni fejn allegatment kien instab imdawwar maghha il-habel li kien gie uzat minn Ricahrd Geoffrey Paxton."*[133]

The cavity within the door frame, wide enough for a rope to go through, provided Paxton with the ultimate contrivance guaranteeing any self-harm prosepcts he held to materialize.

Dr. Joseph Spiteri states: *Mistoqsi dwar il-bieb tac-cella nghid li dan m' ghandux ikun tali li l-pazjent ma jidhirx minn barra u ghalhekk ghandu jkollu vertical bars minn fuq s' isfel u* ***ma jkollu l-ebda kwalita ta'***

[130] Fol.138-139
[131] Fol.140
[132] Fol.42 of the PV. Vide also
[133] Fol.26 of PV

rabta li tista tinqafel mieghu. *Dwar il-perspex fuq wara nghid li hemm bzonn isir xi haga ghax il- perspex jista' jkun ta' periklu ghall- pazjenti."*[134]

Nurse Balzan also mentions how inapt the cell was *"Ma fejn rabat il-habel Paxton fil-frame tal-bieb hemm toqba li facli tista' torbot xi haga maghha"*[135] and *"that particular cell, it wasn't visible on the monitors, it wasn't all visible. Part of it wasnt visible in the monitors. The side of the door was not visible."*[136]. **Gurad Zammit** remarks that in cell 5 *"hemm madwar zewg piedi minnha man-naha tal-bieb li ma jinqabdux. Fil-fatt il-bieb ma tarahx u anki t-tieqa ma tinqabadx kollha. It-tieqa fiha xi tmien piedi jew iktar u kull ma jinqabad xi zewg piedi u nofs jew tliet piedi minnha.* The words by Guard Degiorgio also assume significance on this issue *"kien pazjent naqra jahraq, jigifieri kellu bzonn aktar attenzjoni minn ohrajn tant illi kien f'wahda minn tliet ikmamar intizi ghal dawn in-nies, ghalkemm nghid li mhux daqshekk attrezzati tajjeb ghal dan l-iskop.".degiorgio*

The court appointed expert underlines the threat the cell itself constituted: *"Illi t-toqba fil- hadid fil- kantuniera tal-lemin ta' fuq fuq in-naha ta' gewwa tal-bieb tac-cella li fiha kien hemm Paxton u li maghha nstab sospiz hija bla skop u ghandha tinghalaq immedjatament."*[137].

(c) The Monitors and the Camera in Cell 5

The monitors came under severe criticism by all who worked at the unit as well as by the court experts. CO. Joseph Mifsud describes them as *"l-monitors huma zghar bejn tlieta sa' erbgha pulzieri b'kollox u huma black and white. Taqla' ghajnejk biex tara xi haga u nzid nghid li l-kamra ta' Paxton lanqas taraha kollha. Fil-fatt il-bieb tal-kamra l-camera ma taqbdux……. hemm il-monitors tan-nurses imma huma zghar bhal taghna u mcajprin ukoll.".*[138]

[134] Fol.144
[135] Fol.203
[136] Fol.292-293
[137] Fol.150-151 per Dr. Mario Scerri
[138] Fol.186 PV

S.C.O. Frankie Borg, in-charge of the Forensic Ward, confirmed that nurses had often complained about the poor quality of the monitor's vision during night time: *"Nghid li gieli kellna lmenti minghand xi nurses rigward il- monitors li jintuzaw bhala security fic- cellel ghar-raguni illi dawn kienu mudlama bil- lejl bir- rizultat illi dawn in- nurses ma setghawx jaraw il- monitor sew."*[139]

Dr.Joseph Spiteri also explained how *"il- monitors ma kienux sew fis-sens li ma tantx kienu cari u l- maggur ha action dwar dan il- kaz"* whilst Balzan points out *"Il-monitors li naraw minn fuqhom huma zghar u mudlama hafna li bniedem lanqas taghraf wiccu." Ma fejn rabat il-habel Paxton fil-frame tal-bieb hemm toqba li facli tista' torbot xi haga maghha"*[140].

Dr. Scerri then gives this dscription *"Illi fil- kmamar fejn ikun hemm il- pazjenti li qeghdin jigu osservati hemm camera fuq il- bieb. Fl- opinjoni tal- esponent* ***il- posizzjoni taghha m' huwiex adekwat ghar- raguni illi dak li jigri mal- hajt tal- bieb m' huwiex vizibbli minn dawn il-cameras****. Apparti minn dan meta l- esponent ra l- monitors nhar id- 9 ta' Jannar 2016 deher bic- car illi l- monitors ma kienux cari hafna fis- sens illi wiehed* ***jista' jara x' qieghed jigri pero` huwa difficli biex jgharaf l- ucuh"***.[141]

Duty of Care

However, the deficiencies which have been highlighted do not absolve Toteva from her responsibility in ensuring the safety of the patient she was assigned to watch constantly. The monitors admittedly were of poor quality but gave her sufficient clarity at least to determine that Paxton had moved to the side of the door; she says as much to Balzan. Balzan too, whilst criticizing the monitor's poor vision, could assess that Paxton could not be seen in his cell. Thus, **the monitors in no way impeded Toteva from determining that he had moved out of the camera's range and hence, in itself, this did not detract from her liability to exercise and**

[139] Fol.141
[140] Fol.203
[141] Fol.147-148

perform her duties of constant watch with the diligence expected. She failed in her duty of care towards Paxton; there is no doubt in this. Once Paxton went out of sight, she ought not have remained a passive spectator at the monitors. The least she could have done was ask him to move to a position which could be captured on camera. She could have requested a guard to go and physically check up on him. Nothing impeded her from speaking to him on the monitor until he moved back into her line of vision.

Paxton died within a few minutes after he went out of vision. Yet Toteva remained unperturbed by the fact that he was out of sight until the grim discovery of his lifeless body forty-eight (48) minutes later. It is significant that although she was the one tasked with Paxton's constant watch duties, she was not the one to raise the alarm but it was following Nurse Balzan's actions that Paxton's tragic demise was discovered.

Jurisprudence

The Court of Criminal Appeal in **Il-Pulizija vs Dorianne Camilleri**, decided:[142]

> "In succint fuq skorta ta' awturi u gurisprudenza, t-trepod tal-kolpa gie definit bhala:
> *1. la volontarieta dell'atto;*
> *2. la mancata previsione dell'effetto nocivo; u*
> 3. *la possibilita di prevedere.*
>
> Bhala konkluzzjoni tad-definizzjoni li din il-Qorti trid taghti lit-terminologija culpa, ghalhekk jibqa' dejjem li l-element taghha huwa volontarjeta' tal-att, in-nuqqas ta' previzjoni tal-effetti dannuzi ta' dak l-att u l-possibilta' ta' previzjoni ta' dawk l-effetti dannuzi. Jekk l-effetti dannuzi ma kienux prevedibbli, hlief b'diligenza straordinarja li l-ligi ma tesigix u li semmai tista' ggib culpa levissima li ma hiex inkriminabbli, ma hemmx htija. (vide **Il-Pulizija vs John Vella** deciza nhar il-15 ta' Dicembru 1958 mill-Qorti ta' l-Appelli Kriminali)".[143]
>
> Din is-sentenza tistrieh fuq l-insenjament ta' zewg guristi tad-dritt penali fejn il-gurist **Francesco Carrara** jghid hekk dwar il-*culpa*, "*… il tripode sul quale si aside la colpa sara` sempre questo - 1° volontarieta` dell'atto - 2° mancata previsione dell'effetto nocivo - 3° possibilita` di prevedere*."
>
> Bl-istess mod, il-**Professur Anthony J. Mamo**, fin-noti tieghu, jghid hekk: "*In these definitions the essence of negligence is made to consist in the "possibility of foreseeing" the event which has*

[142] Per Mdme. Justice Edwina Grima, Dec. 28.02.2018; Appeal No..89/2017
[143] Il-Pulizija v Leonard Grech decided by the Court of Criminal Appeals on the 5th September, 1990

not been foreseen. The agent who caused the event complained of, did not intend or desire it, but could have foreseen it as a consequence of his act if he only had minded: so his negligence lies in his failure to foresee that which is foreseeable".

L-**Antolisei**, izda jimxi pass 'il quddiem mill-insenjament tal-Carrara u t-tejorija tal-prevedibbilita ta'l-azzjoni meta iqies illi tirrizulta il-kolpa meta jkun hemm in-nuqqas ta'l-osservanza tar-regoli tal-komportament, anki jekk l-event dannuz ma kienx wiehed prevedibbli u dan billi l-osservanza ta' dawn ir-regoli iwassal sabiex l-event dannuz ma isehhx:

> *"Si tratta di regole di condotta volte a prevenire determinati accadimenti; tali regole possono essere sociali (negligenza imprudenza o imperizia) oppure giuridiche (regolamenti, ordini discipline).*
> *Quindi occorrono due requisiti:*
> *a) la violazione di una regola;*
> *b) che l'evento provocato sia esattamente quello che la norma voleva evitare.*
> *In definitiva il giudizio di rimprovero è un rimprovero per leggerezza, perché il soggetto non è stato cauto e diligente come doveva."*

Awturi ohra bhal **Mantovani** u il-**Padovani** jabbinaw din ir-regola ta'l-Antolisei mar-regoli tal-prevedibbilita u l-inevitabbilita' biex b'hekk il-*culpa* fil-fehma taghhom tinkwadra ruhha f'erba elementi:

> *1. un requisito oggettivo consistente nella violazione di una regola di condotta;*
> *2. un requisito soggettivo, cioè la capacità di osservare tale regola;*
> *3. l'evitabilità dell'evento mediante l'osservanza di tale regola;*
> *4. la prevedibilità ed evitabilità, cioè che il soggetto avesse la capacità o la possibilità di tenere un comportamento diverso.*[144]

Reference is also being made to the judgement in **Il-Pulizija vs Alexander-Roger Manche**:[145]

Illi l-imputat jinsab akkuzat kif diga inghad iktar 'il fuq bir-reat tal-omicidju involontarju. Illi madanakollu l-Qorti tistqarr illi dana il-kaz kien iktar kumpless minn kawzi ohra ta' reati ta' natura involontarja billi jitratta dwar allegat zball kommess minn professjonista fil-kors tal-ezercizzju tal-professjoni tieghu. Kwindi il-Qorti trid necessarjament tinvestiga mhux kwalsiasi eghmil maghmul minn bniedem fil-hajja ordinarja, izda eghmil ta' natura professjonali u l-grad ta' responsabbilta mistennija minn min ipprepara ruhu u ipprezenta ruhu biex jagixxi f'dik il-professjoni partikolari…….

Illi r-reat involontarju gie trattat b'mod kopjuz fil-gurisprudenza taghna u l-elementi li isawwru dana ir-reat gew studjat *funditus* fejn gie spjegat il-kuncett tal-kulpa fil-ligi Maltija.

Illi fis-sentenza moghtija mill-Qorti Kriminali fl-ismijiet **Il-Pulizija v. Perit Louis Portelli**, (04/02/1961), il-kompjant Imhallef Flores stqarr:

> **"Hu mehtieg ghall-kostituzzjoni tar-reat involontarju skond l-art.239 (illum 225) tal-Kodici Penali illi tirrikorri kondotta volontarja negligenti konsistenti generikament**

[144] http://www.altalex.com/documents/altalexpedia/2016/02/17/colpa
[145] Per Magistrate Edwina Grima; Dec. 6th August, 2013

f'nuqqas ta' hsieb f'("imprudenrza"), traskuragni ("negligenza"), jew nuqqas ta' hila ("imperizia") fl-arti jew professjoni jew konsistenti specifikatament f'nuqqas ta' tharis tar-regolamenti li tkun segwita b'ness ta' kawzalita' minn event dannus involontarju;

"Ghandu jigi premess illi, ghall-accertament tal-htija minhabba f'kondotta negligenti, ghandu isir il-konfront tal-kondotta effettivament adoperata ma' dik ta' persuna li s-sapjenza rumana identifikat mal-"bonus pater familias"; dik il-kondotta, cioe', illi fil-kaz konkret kienet tigi wzata minn persuna ta' intelligenza, diligenza u sensibilita' normali: kriterju dan li fil-waqt li jservi ta' gwida oggettiva ghall-gudikant ihallieh fl-istess hin liberu li jivaluta d-diligenza tal-kaz konkret. "La diligenza del buon padre di famiglia costituisce un criterio abbastanza indeterminato per lasciare al giudice gran liberta' di valutazione" (Giorgi, Teoria delle Obbligazioni, 11,27 , p. 46);

Illi l-gurisprudenza izzid ukoll illi ma' dawn l-elementi irid ikun hemm necessarjament l-element ta' preveddibilita' u cioe' illi l-agent jonqos volontarjament milli jagixxi b'diligenza tant illi b'tali agir ikun prevedibbli (u mhux previst) li jista' isehh l-event dannuz. Illi **Francesco Antolisei**, fil-ktieb tieghu Manuale di Diritto Penale, Parte Generale jghid hekk:

:"***Secondo la dottrina tradizionale che vanta origini antichissime e in questi ultimi tempi torna a prevalere, la colpa consiste nella prevedibilita' del risultato non voluto. Scrisse il Carrara: "La colpa si definisce la volontaria omissione di diligenza nel calcolare le conseguenze possibili e prevedibIli del proprio fatto. Dicesi conseguenza prevedibile, perche' l'essenza della colpa sta nella prevedibilita'.***"

Illi din hija t-tezi li dejjem giet accettata mill-Qrati taghna. Fis-sentenza tal-Qorti ta' l-Appell Kriminali fl-ismijiet **Il-Pulizija v. Richard Grech** (21.03.1996), gie deciz li jekk il-prudenza tikkonsisti filli persuna taghmel dak li hu ragjonevolment mistenni minnha sabiex tipprevjeni l-konsegwenzi dannuzi ta' ghemilha, l-imprudenza, li hi n-negazzjoni ta' din il-virtu', tikkonsisti filli wiehed jaghmel avventatament dawk l-affarijiet li hu messu ppreveda li setghu jikkagunaw hsara. It-traskuragni, mill-banda l-ohra, timplika certa non-kuranza, certu abbandun kemm intellettiv kif ukoll materjali. Fiz-zewg kazijiet, pero', il-hsara tkun prevedibbli ghalkemm mhux prevista: kieku kienet ukoll prevista, wiehed ikun qieghed fil-kamp doluz b'applikazzjoni tad-dottrina ta' l-intenzjoni posittiva indiretta.

Illi, kif jispjega Sir Anthony Mamo fin-noti tieghu, il-ligi ma taghtix definizzjoni tal-frazijiet "nuqqas ta'hsieb", "traskuragni" u "nuqqas ta' hila" izda "*it is clear that by them the law means generally the absence of such care and precautions as it was the duty of the defendant to take in the circumstances*."

Illi minn dina l-gabra ta' dottrina u gurisprudenza, jirrizultaw ghalhekk is-segwenti elementi essenzjali li iridu jissussistu sabiex tinstab htija ghar-reat ta' natura involontarja**:**

1. **azzjoni volontarja negligenti, imprudenti u non-kuranti.**
2. **ness bejn l-azzjoni jew in-nuqqas taghha u l-event dannuza.**
3. **l-element tal-prevedibbilita'**

Ikkunsidrat,

Illi stabbiliti dawn l-elementi legali, kwindi, din il-Qorti trid tara jekk l-imputat:

1. kienx negligenti, imprudenti u non-kuranti fl-agir tieghu.
2. jekk dana jirrizulta, jekk kienx hemm ness bejn dana l-agir tieghu u l-event dannuz.

3. jekk il-hsara kenitx wahda prevedibbli.

Illi kif diga inghad mill-Qorti sabiex jigi ezaminat l-eghmil ta'l-imputat u jekk dana kienx negligenti, imprudenti u non kuranti dana irid necessarjament jigi studjat fl-ambitu tal-errur professjonali. Illi l-ligi taghna ma taghti l-ebda definizzjoni dwar l-grad ta'responsabbilta' li ghandu jigi ezercitat minn tabib jew kirurgu fl-esercizzju tal-professjoni tieghu. Illi l-gurisprudenza dejjem imxiet mar-regola illi mhux kull zball ta' natura professjonali jaqa' fir-relm tal-kulpa diment dana ma ikunx sehh minhabba negligenza, imprudenza jew non kuranza. Illi fis-sentenza hawn fuq iccitata Il-Pulizija vs Louis Portelli, l-Qorti Kriminali ghamlet referenza ghal dak stabbilit mill-awtur **Giovanni Cattaneo** fit-tratta tieghu "*La responsabbilta del professionista*" fejn ighid:

> "**L'errore professionale … si ha quando la condotta risulti non obiettivamente adatta al caso concreto sebbene il professionista abbia agito diligentemente, facendo quanto gli suggerivano le conoscenza proprie del buon professionista della sua categoria; se poi, verificatosi l'esito negattivo, si sopre che la condotta per ottenere il risultato avrebbe dovuto essere diversa, nulla puo' rimproverarsi al professionista, che non era in grado di rendersene conto preventivamente**."

Ikompli:

> "**Cosi' inteso, l'errore professionale e' allora in sostanza un comportamento tecnicamente errato ma non necessariamente colposo, che e' causa del mancato raggiungimento del risultato utile che mira il cliente. Il problema dell'errore proessionale viene percio' a coincidere con quello del nesso casuale tra inadempimento e danno. Infatti se il risultato infausto si verifica indipendentemente dal comportamento del professionista, manca il nesso casualita', che e' invece presente in caso di errore colpevole. Se cio' e' vero, il concetto di errore professionale risulta in sostanza inutile, perche' non aggiunge nulla al concetto di casualita' che e' lo stesso per ogni sorta di danno, anche al di fuori della responsabbilita' professionale … Si puo' solo notare che il nesso casuale si presenta sotto diverso aspetto, a seconda che l'esito della attivita' dipenda, oltre che dall'attivita' del professionista, da una serie di fatti naturali oppure da atti volontari di terze persone.**"

Illi fis-sentenza iccitata intqal:

> "**Kunsidrat f'dan l-aspett l-errur professjonali, il-Qorti taghmel taghha, ghall-apprezzament tal-provi il-kliem ta' Cogliolo (Teorie Delle Colpe, Vol,II, p.137):- 'Nelle professioni c'e tutto un campo insindicabile ed inespugnabile, ed e' quello che il diritto inglese chiama errore di giudizio. Il professionista cioe' di fronte ad un caso pratico, valuta le varie circostanze, e si forma un convincimento che poi i fatti successivi mostrano errato; di questo errore nessuno responde, se non e' fondato su evidenti errori di ricerca e di dottrina'**."

Illi l-Imhallef Flores f'din is-sentenza ighallimna illi f'kaz tal-professjonista id-diligenza li dan ghandu jadopera hi dik ta' bniedem ordinarjament kompetenti fil-professjoni tieghu. Jekk jiehu zball fil-professoni tieghu, huwa ma jirrispondiex ghad-danni jekk l-izball ma jkunx grossolan u jekk tkun giet minnu adoperata d-diligenza ordinarja li trid il-ligi. Huwa mhux tenut ghad-danni rizultanti minn zball professjonali, ammenocche' dana l-izball ma jkunx grossolan u

ammenocche' l-htija ma tkunx tista' tigi lilu addebitata minhabba nuqqas ta' prudenza u attenzjoni ta' missier tajjeb tal-familja.

Fl-istess vena fis-sentenza **Victor Savona pro.et.noe. vs Dr. Peter Asphar et** gie deciz:

> "**Mid-duttrina u mill-gurisprudenza fuq iccitata ghandu jigi ritenut li t-tabib mhux tenut ghad-danni rizultanti minn zball professjonali ammenokke dana l-izball ma jkunx grossolan, u ammenokke' il-hsara ma tistax tigi lilu addebitata minhabba nuqqas ta' prudenza, dilgenza u attenzjoni ta' 'bonus pater familias'**."

Allura sa fejn tasal ir-responsabbilta' tat-tabib. Iwiegeb hekk il-Laurent[146]:

> "**Non e' possibile determinare in modo generale il limite delle responsabbilita' dei medici. Spetta al magistrato ravvisarle in ciascuno specie, secondo i fatti e le circostanze, che possono infinitamente variare, non perdendo mai di vista quel principio fondamentale che deve sempre servigli di guida, val dire che per aversi responsabbilta' professionale a d'uopo che taluno abbia comesso colpe non usando le volute vigilanze sopra se' medesimo o sui propri atti, o dando prova di ignoranza imperdonabile nell'esercizio della sua professione; spetta ai tribunali applicare questa massima con discernimento, lasciando alla scienza tutta la latitudine che si deve, ma accordando del pari alla giustizia a al diritto tutto quanto loro appartiene**."

Ukoll l-Archbold jishaq:

> "**A physican or surgeon owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering treatment, and the law requires not the highest or a very high standard, but a fair and reasonable standard of care and competence.**"

Illi abbinat ma' dan il-grad ta' responsabbilta', allura huwa hawnhekk illi jaghmel sens l-element tal-preveddibilita' rikjest fid-dritt penali. Dana ghaliex l-professjonista li volontarjament huwa negligenti u imprudenti jista' jasal jikkaguna hsara li hija prevedibbli bhala konsegwenza ta'l-azzjonijiet tieghu. U hawnhekk allura ikun hemm in-ness bejn l-azzjoni u l-event dannuz li jista' iwassal ghal htija…….

In a decision delivered by the House of Lords in **Regina v. Adomako (Appellant) (On Appeal from the Court of Appeal (Criminal Division)).** It was stated:[147]

> "In cases of manslaughter by criminal negligence involving a breach of duty, it is a sufficient direction to the jury to adopt the gross negligence test set out by the Court of Appeal in the present case following *Rex. v. Bateman* 19 Cr.App. R.8 and Andrews *v. DPP* [1937] AC 576 and it is not necessary to refer to the definition of recklessness in *R.-v. Lawrence* [1982] A.C. 510, although it is perfectly open to the trial judge to use the word "reckless" in its

[146] Principio di Diritto Civile Vol.XX para 156 pg.422

[147] **R v Adomako [1994]** UKHL 6 (30 June 1994)

ordinary meaning as part of his exposition of the law if he deems it appropriate in the circumstances of the particular case";

Lord Chancellor, Lord **MACKAY OF CLASHFERN** stated:

……The Court of Appeal held that except in cases of motor manslaughter the ingredients which had to be proved to establish an offence of involuntary manslaughter by breach of duty were the existence of the duty, a breach of the duty which had caused death and gross negligence which the jury considered to justify a criminal conviction; the jury might properly find gross negligence on proof of indifference to an obvious risk of injury to health or of actual foresight of the risk coupled either with a determination nevertheless to run it or with an intention to avoid it but involving such a high degree of negligence in the attempted avoidance as the jury considered justified conviction or of inattention or failure to advert to a serious risk going beyond mere inadvertence in respect of an obvious and important matter which the defendant's duty demanded he should address;……

Like the Court of Appeal your Lordships were treated to a considerable review of authority. I begin with ***Rex. v. Bateman*** **19 Cr. App. R. 8** and the opinion of Lord Hewart C.J., where he said, at pp. 10-11:

> "In expounding the law to juries on the trial of indictments for manslaughter by negligence, judges have often referred to the distinction between civil and criminal liability for death by negligence. The law of criminal liability for negligence is conveniently explained in that way. If A has caused the death of B by alleged negligence, then, in order to establish civil liability, the plaintiff must prove (in addition to pecuniary loss caused by the death) that A owed a duty to B to take care, that that duty was not discharged, and that the default caused the death of B. To convict A of manslaughter, the prosecution must prove the three things above mentioned and must satisfy the jury, in addition, that A's negligence amounted to a crime. In the civil action, if it is proved that A fell short of the standard of reasonable care required by law, it matters not how far he fell short of that standard. The extent of his liability depends not on the degree of negligence but on the amount of damage done. In a criminal court, on the contrary, the amount and degree of negligence are the determining question. There must be mens rea."…..
> ….

Next I turn to ***Andrews v. Director of Public Prosecutions*** **[1937] A.C. 576** which was a case of manslaughter through the dangerous driving of a motor car. In a speech with which all the other members of this House who sat agreed, Lord Atkin said, at pp. 581-582:

> "….. In the present case it is only necessary to consider manslaughter from the point of view of an unintentional killing caused by negligence, that is, the omission of a duty to take care. …..

> In my opinion the law as stated in these two authorities is satisfactory as providing a proper basis for describing the crime of involuntary manslaughter. ……
>
> On this 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 criminal.**

In its judgement in the names ***Il-Pulizija vs Anthony Calleja,*** a case which similarly involved a nurse being accused of involuntary homicide after the suicide of a patient who was on level 1 constant watch, the Court of Appeal held:[148]

> "L-artikolu 225 tal-Kap 9 jinkludi l-kelma 'negliġenza' u l-fraži 'nuqqas ta' ħarsien tar-regolamenti'.
>
> Skont il-Professur Mamo (Ara n-Noti tiegħu fl-Ewwel Parti – Notes on Criminal Law pages 69 and 70.):
>
> > 'Now the words 'negligence, imprudence, carelessness' are not defined but it is clear that by them the law means generally the absence of such care and precautions as it was the duty fo the defendant to take in the circumstances…
> >
> > Now the question arises whether in the system of our Code it is essential, in order that there may be liability for a negligent offence, that the harm caused should have been foreseeable by the defendant. It would appear that the answer to this query should be in the affirmative.'
>
> Wara li l-Professur jgħid li l-provvedimenti tagħna huma dawk tal-Kodiċi Taljan tas-sena 1898, il-Professur ikompli hekk:
>
> 'the words 'negligence' 'imprudence' and 'carelessness' are subjective facts. They connote the subjective attitude of the offender towards his acts and their consequences which prevents him from acquiring foresight and consciousness of them and but for which he could have acquired such foresight and consciousness.'
>
> Fin-noti u fis-sottomissjonijiet saret referenza għad-deċiżjoni 'Il-Pulizija vs Pawlu Spiteri et' tal-Qorti tal-Appell Kriminali tat-3 ta' Ġunju 1961. Dan il-każ kien dwar korriment f'barriera fejn is-sid inżamm responsabbli minħabba li ma kienx ħa ħsieb il-makkinarju. Il-Qorti qalet hekk:

[148] Hon. Mr. Justice Lawrence Quintano. Judgement of the 8th October, 2012. Criminal Appeal no. 448/2011

‘La darba n-negliġenza tkun ‘gross and culpable’ hija tagħti lok mhux biss għal responsabilita’ ċivili imma anke kriminali.’

F’każ ieħor tal-Qorti tal-Appell Kriminali (19 ta’ Jannar 1963) ‘Il-Pulizija versus Colonel Stephen J Borg’, kien intqal hekk:

‘In-negliġenza fis-sens tad-dritt kriminali għandha tkun such culpable negligence as to amount to criminal misconduct’……

Il-Qorti sejra tapplika dawn il-prinċipji għall-każ ta’ llum.

L-appellant kien jaf ben tajjeb li għandu pazjent bi problemi serjissimi tant li hu stess talab (a) li t-tabib forsi jagħtih xi ħaġa aktar qawwija u /(b) li jittieħed fis-seclusion room. L-appellant kien jaf ukoll li l-pazjent kien qiegħed taħt **level one supervision**, fraži li tfisser li għandek a ‘high risk patient’ kif joħroġ mill-Protocol Document tad-Dipartiment innifsu.

Mhix kwistjoni ta’ kemm għandek taħriġ jew le. L-importanti huwa li jkollok eye to eye contact u li ssuperviżjoni tkun ‘at arm’s length.’. Ukoll jekk l-aħħar fraži ma tfissirx li wieħed irid ikun eżatt ma’ ġenb il-pazjent, iżda tfisser ċar li lill-pazjent ma tistax titilqu mument minn taħt għajnejk. …..Bir-rispett kollu, l-isptar ipprovda għal one to one u bozza maqtugħa mhix raġuni biżżejjed biex twassal għal dak li ġara……

Dwar is-superviżjoni fit-toilet, il-Qorti tifhem li l-appellant ma riedx jikser il-privatezza tal-pazjent. Ikkonsidrat ukoll ix-xhieda ta’ Publius Frendo li mhix prattika li l-infermier jidħol ħdejn il-pazjent.

Iżda importanti ferm li żżomm kuntatt bil-kliem mal-pazjent meta jkun daħal fit-toilet. Għandek ukoll tieqa żghira fi-lbieb biex jekk tħoss li hemm il-bżonn jew ġiek xi dubju, allura tinsa l-privatezza u tittawwal.

Minn dak li qal l-appellant waqt l-inkjesta jirriżulta li hu ma kienx wara l-bieb eżatt iżda wara l-bieb tal-kuritur.

Minħabba li d-distanza mill-pazjent twalet, is-sitwazzjoni li jkun jaf x’qed jiġri saret impossibbli. Ma setax jżomm dak il-kuntatt mal-pazjent u / jew li juża t-tieqa ż-żgħira biex jara kienx qed jiġri xi ħaġa ta’ perikolu. (U dan fi sfond ta’ użu tat-toilet darbtejn fuq xulxin)

Barra minn dan, l-appellant missu qagħad aktar attent meta nduna li l-pazjent dieħel fit-toilet it-tieni darba fi ħin tant viċin tal-ewwel vista. Hawnhekk żgur kellu jkun ‘full alert’ meta kien jaf li l-pazjent kien aġitat u kien ilu jippassiġġa. Kien jaf ukoll li l-pazjent kien għamel tentattiv ta’ suwiċidju ftit qabel.

U l-Ewwel Qorti kompliet hekk:

‘Inġab minn fejn inġab il-liżar li bih tgħallaq Schembri, Schembri kellu dak iċ-ċans kollu li jqatta’ l-liżar min-nofs u jitgħallaq bih – dan meta suppost kien qed juża t-toilet.

Ma tistax ma tistaqsix il-Qorti hawn, allura l-imputat li suppost qed iżomm ‘constant watch – at arm’s lenth – eye contact’ ma’ dan il-pazjent, f’dan il-ħin fejn kien?’…….

> Il-Qorti qed tikkonkludi li l-appellant **seta' jipprevedi** li l-imġieba ta' Richard Schembri setgħet tkun ta' perikolu.
>
> Jekk huwa segwih il-ħin kollu, kif xehdu bosta infermiera, kif **f'dan il-mument donnu ħallih jaħrablu minn taħt għajnejh**. [Emphasis of the Court]

The same reasoning can be applied to the facts of this case. It is imperative that **a person entrusted with constant watch duties had to ensure that a high-risk patient is kept out of harm's way at all times, no interludes, no pause, no exception**. Toteva should never have allowed the patient to stay out of sight and if he had done so, she was duty bound to exercise a much greater supervision over him; her duty was precisely that of ensuring that for the while he was out of sight, he was at all times kept away from harm's way, if necessary engaging in conversation with him to allay any cause for concern.

This is where Toteva failed to exercise the diligence expected of her. An expectation compounded by the fact that **at the time of the incident she was vested with the duty of care** towards Paxton, a duty which she neglected when she failed to foresee the obvious; a high risk patient with suicidal and self-harm tendencies who had already tried to commit suicide on two other occasions, recedes precisely to a spot which is not captured by cameras. That in itself should have been alarming!

The fact that he remained hidden and there was no communication with him, no intervention on her part to ensure he is not endangering himself, is tantamount to a dereliction of the duty of care. Her failure was to foresee the foreseeable thereby failing to exercise the diligence expected of her also in conformity with the rules governing Level 1 supervision.

The defendant's submissions that she was entrusted with other duties apart from that of exercising level 1 supervision, that she had tended to the inmate a few minutes earlier when she lit a cigarette for him and brought him tea, remain uncorroborated. To the contrary evidence by her immediate superior revealed that nurses exercising level 1 supervision are tasked to do just that and nothing else. CCTV footage shows another nurse attending to Paxton and not Toteva, thus contradicting her claims that minutes earlier she had tended to him besides being on constant watch duties.

This notwithstanding, and as already pointed out, Yulia Toteva should not be the only one to carry the brunt of responsibility for Paxton's demise. Others were also negligent thereby failing the inmate and ultimately the system itself! This consideration weighed heavily on the Court in its determination of the punishment to be meted out.

In other considerations on punishment the Court took into account the clean criminal record of the accused. Note was also taken of the statement made by her superior when he described the defrendant as *"a hard worker, she is one of the best"*.[149]

For the said reasons the Court, after seeing article 225(1) of the Criminal Code, finds the defendant guilty of the charge brought against her and condemns her to the payment of a fine (*multa*) of five thousand Euros (€5,000).

The court orders that the register[150] be returned to the administrator of the Forensic Unit within Mount Carmel Hospital and the medical history file to Corradino Correctional Facilities.[151]

Finally, in terms of Article 533 of Chapter IX of the Laws of Malta and in view of the above-made observations regarding the negligence encountered within the unit, the defendant is being ordered to pay the sum of €860.37 representing one third of the expert fees.[152]

Dr. Donatella M. Frendo Dimech LL.D., Mag. Jur. (Int. Law)
Magistrate

[149] Fol.413
[150] Fol.364
[151] **Dok.MS 1** a fol. 172
[152] €2,581.11 being the whole amount.