CASE LAW UPDATES

Clare Duffy, Doughty Street Chambers

THE LIMITED SCOPE OF REPORTING RESTRICTIONS UNDER S.39 OF THE CHILDREN AND YOUNG PERSONS ACT 1933

Re AB (Application for reporting restrictions: Inquest) [2019] EWHC 1668 (QB)

BACKGROUND

The applicant, Worcestershire County Council (the Council), sought a wide-ranging reporting restrictions order from the High Court for an upcoming inquest into 17 year old AB's death. The stated purpose was to protect AB's surviving siblings - who were vulnerable minors in foster care - from distressing evidence about their sister taking her own life and allegations of sexual abuse. The Council sought to prohibit the publication of (i) AB's identity and date of birth, (ii) the names of AB's parents, (iii) the names and dates of birth of AB's siblings, and (iv) findings of sexual abuse by AB's father and by one of her siblings.

The Council purportedly sought the order pursuant to s.39 of the Children and Young Persons Act 1933. Section 39 empowers a court to prohibit the publication of certain details about a minor 'concerned' in non-criminal proceedings – i.e. a person by / against / in respect of whom the proceedings are taken or a person who is a witness. The relevant details are the minor's name, address or school, "any particulars calculated to lead to [their] identification" and their photo.

The Council's application was made without any notice to the other interested parties in the inquest and without proper notice to the media. The Respondent was generically listed as the 'National News Media'. The Council served an application notice and an explanatory note by e-mail to the Press Association's Copy Direct service and by post to local newspapers. Anticipating success, the only information provided was that a s.39 "reporting restriction order has been made to protect AB and her siblings for an unnamed inquest listed on specified dates". No witness statements or legal submissions were served.

JUDGMENT

Mr Justice Pepperall held that the Council's inadequate approach to service was "sufficient to dismiss this application" (para. 21):

- The Council had "not taken all practicable steps" to notify the media about the application and there were no compelling reasons why proper notice of the application could not be given, as required by s.12 of the Human Rights Act 1998. "[N]otice simply that an application is being made in respect of some unidentified person's inquest and stripped of the evidence and full argument in support is not proper notice" (para. 18-19).
- The Council had taken "no steps whatsoever" to notify other obviously interested parties in the inquest, who were entitled to proper notice of the application and to supporting evidence (para. 18).
- Overall, the Court held that "justice is not done by one party enjoying privileged access to the judge and placing before the court evidence and argument that it is not willing to share with the other parties" (para. 20).

Additionally, the Council had made the incorrect application to the wrong court:

- A s.39 application can and should be made to the coroner. The coroner would have a far greater understanding of the issues in the inquest and the ability hear all interested parties and media attending the inquest before ruling on the application. The High Court should not "unnecessarily take on the mantle of making the original decision, especially where it does not have all the proper parties before the court and does not have the benefit of adversarial argument" (para. 23).
- The order sought by the Council did not fall within the scope of s.39 given that the siblings would not be witnesses at the inquest. Instead, the 'true application' before the Court was for the exercise of the court's inherent jurisdiction, balancing the siblings' Article 8 rights against the Article 10 interest in free reporting of the case (para. 24).

COMMENT

The judgment is a salutary reminder of getting the basics right: making the correct application to a court with jurisdiction on proper notice. The Council's fundamental errors are surprising, given that the Chief Coroner issued Guidance Note no.25 on 'coroners and the media' in 2016. That Guidance clearly sets out the circumstances in which a coroner may impose reporting restrictions. In short, the coroner must always take the principle of open justice into account and may impose reporting restrictions only when "lawful, necessary and proportionate" and "limited to the minimum required to protect the interests in issue" (para. 67-68). The Guidance also clearly sets out the "limited" scope of s.39, expressly stating that it cannot be used to provide anonymity for a deceased child or a child otherwise referred to in the evidence (para. 72-77).

WHEN THE DISCOVERY OF NEW FACTS AND EVIDENCE RENDERS A FRESH INQUEST NECESSARY

Frost v HM Coroner for West Yorkshire (Eastern District) [2019] EWHC 1100 (Admin)

BACKGROUND

A 1966 jury inquisition into the murder of 14 year old Elsie Frost named Ian Bernard Spencer as the perpetrator. Later that year Mr Spencer was committed for trial under s.25 of the coroner's (Amendment) Act 1926, but the Crown offered no evidence against him. A not guilty verdict was entered, but the record of inquisition remained unamended.

In 2015 West Yorkshire Police opened a new inquiry into the murder. That investigation implicated another man, Peter Pickering. In summer 2017 the file was sent to the CPS for a charging decision. However Mr Pickering died before a decision was made.

The Claimant, Elsie's younger brother, applied under s.13 of the coroners Act 1988, with a fiat from the Attorney General, for an order quashing the original inquisition and directing that a fresh inquest take place. Section 13 provides that the High Court has the discretion to do so following "the discovery of new facts or evidence" if satisfied that "it is necessary or desirable in the interests of justice".

The Claimant made four core submissions:

- The public record should accurately reflect what was known about the circumstances of Elsie's death.
- The inquisition continued to name Mr Spencer as responsible for Elsie's murder notwithstanding evidence that another person was the killer.
- A key function of an inquest was to allay rumour or suspicion in respect of Mr Spencer.
- There was an important public interest in investigating the facts of Elsie's death in light of a recent, wide-ranging, comprehensive and thorough police inquiry.

JUDGMENT

The Divisional Court accepted the Claimant's submissions in their entirety, ruling that "the discovery of new facts or evidence…may reasonably lead to the conclusion that the substantial truth about how Elsie met her death was not revealed at the first inquest". In reaching that conclusion the Court did not have access to the police investigation file, but inferred the likely nature and range of "new facts or evidence" from the scope of the police's new inquiry and the request for a CPS charging decision (para. 41).

The Court agreed that a fresh inquest was necessary (and, it followed, also desirable) in the interests of justice, notwithstanding the passage of some 53 years. The Court readily accepted that the matter remained extremely important for both the Frost and Spencer families (para. 42). Although modern juries are restricted from pronouncing on matters of criminal liability, a "fully, fairly and fearlessly investigated" *Jamieson* inquest would both cover new facts bearing on criminal liability and correct the former record (para. 43-45). The deaths of Mr Spencer and Mr Pickering did not render a fresh inquest futile, unnecessary or undesirable. Criminal proceedings in respect of Mr Pickering that may have obviated the need for a further inquest could not occur. In any event, Mr Pickering's estate could apply to participate in the fresh inquest as an interested person under s.47 of the coroners and Justice Act 2009 (para. 46-47).

COMMENT

The case provides guidance for Claimants seeking to establish that a fresh inquest is necessary. The judgment affirms that it is not incumbent on Claimants to show a different outcome would arise from the inquest. The Defendant coroner had questioned the value of a fresh inquest submitting that "the most that could be achieved at a fresh inquest would be to re-affirm that Elsie Frost had been unlawfully killed" (para. 38). However, the Court held that the process of public examination of newly available evidence, rather than the outcome of that examination, was determinative. In the present case, that process would provide sufficient resolution for the families after so many years (para. 46).

THE CORONER'S BROAD DISCRETION TO ADMIT / REFUSE EVIDENCE

R (Carwyn Jones) v HM Senior

CASE LAW UPDATES

Clare Duffy, Doughty Street Chambers

Coroner for North Wales (East & Central) [2019] EWHC 1494 (Admin)

BACKGROUND

The claim arose out of the inquest into the death of Carl Sargeant AM on 7 November 2017, four days after the Claimant (the former first Minister of Wales) removed him from the Welsh Government Cabinet following allegations of sexually inappropriate behaviour by three women.

The Claimant twice applied to admit additional evidence from four witnesses relating to the allegations of sexual misconduct that would have caused Mr Sargeant real anxiety if made public. The coroner rejected both applications finding that there was sufficient evidence before him to perform his duties under s.5 of the Coroners and Justice Act 2009. The inquest was adjourned part-heard while the Claimant challenged the coroner's decision.

The Claimant's judicial review advanced six grounds submitting that the coroner erred in law by (i) failing to take into account relevant matters; (ii) taking into account irrelevant matters; (iii) failing to give reasons; (iv) failing to ensure there was a full, fair and fearless investigation; (v) placing too great a weight on statutory questions, and (vi) reaching an irrational decision.

JUDGMENT

In rejecting the Claimant's application, the Administrative Court roundly dismissed all six grounds, finding that the coroner had acted "conspicuously fairly and in accordance with his statutory duties" (para. 24).

- Grounds (i) and (ii): there was "no doubt" that the coroner directed himself properly in law. The coroner had a wide discretion when it came to the admission of evidence. The matters that the coroner had allegedly failed to consider were either "self-evident" or having been raised in oral submissions could "plainly…not have been overlooked". Moreover, it was "perfectly natural" that the coroner had regard to the need to avoid unnecessary distress to persons appearing before him (para. 16-17).
- Ground (iii): the coroner had given "very full" reasons (cited in full by the Court) and the Claimant's "real complaint" was that the coroner had rejected his submissions on their merits (para. 11, 18).
- Grounds (iv) and (v): these grounds added nothing to the claim, given that the coroner directed himself entirely correctly as to the scope of a s.5 inquest. As the inquest was part-heard, the claimant's submission that a "full, fair and fearless investigation" was not being conducted was arguably "premature" (para. 19).
- Ground (vi): the submission that the coroner had acted irrationally was "hopeless". The coroner had evidence before him on (i) Mr Sargeant's history of depression, (ii) his dismissal on 4 November 2017 amidst publicity, (iii) the Claimant receiving allegations of sexual impropriety and (iv) Mr Sargeant's suicide note. The further evidence requested by the Claimant was not necessary for the coroner to discharge his statutory functions (para. 20-24).

COMMENT

This case reiterates the width of coronial discretion regarding what evidence to admit and what not to admit, particularly in *Jamieson* inquests. A Claimant seeking to challenge coronial admissibility decisions faces a high threshold, particularly if the evidence is peripheral to the four questions to be answered and/or engages in speculation about broader circumstances in which a person died.

The Claimant came under particular criticism for making submissions "based, essentially, on speculation" about what the evidence may or may not show. The Court commented that it was "unfortunate" that the application may itself have given rise to "further considerable and unnecessary speculation about this evidence" and that it was not appropriate for Courts to be asked to intervene on the basis of speculation (para. 24).

INCLUDING FACTUAL FINDINGS ON THE RECORD OF INQUEST THAT DID NOT CAUSE OR CONTRIBUTE TO DEATH

R (Worthington) v Senior Coroner for Cumbria [2018] EWHC 3386

BACKGROUND

A key issue in the inquest into the death of 13 month old Poppi Worthington was whether she had been sexually assaulted in the hours before her death and, if so, whether that had led to her death. The coroner found on the balance of probabilities that Poppi had been taken from her own cot to a double bed where she was sexually assaulted by anal penetration, but that the penetration had not caused or contributed to her death. Poppi had died as a result of her ability to breathe being compromised by an unsafe sleeping environment (a double bed with an adult sleeping close to her).

The Claimant, Poppi's father, did not challenge the scope of the inquest or the coroner's finding that penetrative assault occurred. He submitted that the coroner erred in recording the fact of anal penetration in two paragraphs of a lengthy "Review of Evidence, Findings and Conclusion" ('the Review') and in Box 3 of the Record of Inquest. By way of relief, he sought an order requiring removal of those references from the Review and the Record of Inquest.

The challenge relied on s.5(1)(b) and (3) read in conjunction with s.10 of the Coroners and Justice Act 2009. In brief, those sections collectively provide that the purpose of an inquest to ascertain "how, when and where" the deceased came by her death and prevent the coroner from expressing an opinion on any other matter in his determination. The Claimant submitted that the coroner did not confine himself to ascertaining and recording "how" Poppi came by her death, but inappropriately and unlawfully trespassed into the circumstances in which it occurred.

JUDGMENT

The Divisional Court (which included the Chief Coroner of England and Wales on its three judge bench) dismissed the claim. The Court was unconvinced by Claimant's characterisation of the two impugned paragraphs in the Review as part of the coroner's "determination" and considered that the "proper focus" of the Claimant's complaint was the reference to anal penetration in Box 3 (paragraph 34-37).

Irrespective of whether a restrictive and expansive view of "determination" was taken, the coroner did not err in recording his finding of anal penetration (para. 38). None of the references expressed an opinion and none went beyond the "how" question of a *Jamieson* inquest by making a determination of the wider circumstances attending Poppi's death (para. 39-40). It was a matter of coronial discretion and judgement which findings of fact go into the determination of how someone came by their death (para. 41). Moreover, it was a function of an inquest to seek out and record as many of the facts concerning the death as the public interest requires, without deducing from those facts any determination of (civil or criminal) blame (para. 43).

In the Court's view, the coroner's approach and conclusions could not be faulted. Regarding Box 3, the coroner was "entitled" and "right" to conclude that it was appropriate to include references to the anal penetration before Poppi's death because it was essential to explain why Poppi was in the unsafe sleeping environment which caused her death. Regarding the Review, it was clearly necessary for the coroner to explain why he concluded that Poppi's death was not an unlawful killing or accidental death. The coroner used "patently careful and appropriately neutral language" in referring to the anal penetration. Were the references to anal penetration struck out, then the Record of Inquest would be deficient: it would fail to adequately explain why Poppi was in the unsafe sleeping environment (para. 46-47).

COMMENT

This unanimous judgment will be a go-to authority for interested persons seeking to persuade a coroner to include certain factual findings on the face of the Record of Inquest. The judgment clearly and authoritatively sets out that a coroner may include findings that form part of the immediate circumstances of death in Box 3, even if they are not causative or contributory.

However, the judgment is not clear as to when a coroner *must not* omit to record factual findings. The Court commented obiter that setting out a negative conclusion "may be appropriate or even obligatory to ensure the legal requirements for such a determination are met" (para. 46) [emphasis added]. The Court provided no guidance regarding what features of a particular case would curtail a coroner's discretion. As such, it is likely that future judicial reviews will focus on challenging a coroner's decision not to include facts in a determination, rather than a decision to do so.

A second notable aspect of the judgment is that the Court awarded costs to the coroner, despite his purportedly 'neutral' stance. In reality the coroner had made both written and oral submissions against the redactions sought by the Claimant. This finding cuts both ways: successful Claimants should not be dissuaded from seeking costs from coroners that feign a neutral position while opposing their application (para. 59-61).