Neutral Citation Number: [2017] EWCA Civ 318

Case No: C1/2016/1824

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION ADMINISTRATIVE COURT
Mr Justice Kerr
CO/6407/2015

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 28/04/2017

Before:

LORD CHIEF JUSTICE OF ENGLAND AND WALES
LORD JUSTICE BURNETT
and
LORD JUSTICE IRWIN

- -

Between:

The Queen on the application of T	**Appellant**
- and -	
HM Senior Coroner for the County of West Yorkshire (Western Area)	**Respondent**

- -
- -

Stephen Cragg QC & James Robottom (instructed by **Howells Solicitors**) for the **Appellant**
Jenni Richards QC (instructed by **City of Bradford Metropolitan District Council**) for the **Respondent**

Hearing dates: 21 & 22 February 2017

- -

Approved Judgment

Lord Thomas of Cwmgiedd:

This is the judgment of the court to which each of us has contributed.

1. Two issues arise for determination in these judicial review proceedings. First, whether the Senior Coroner for West Yorkshire ["the Coroner"] is entitled to conduct an investigation and inquest, pursuant to s.1 of the Coroners and Justice Act 2009, into the question whether a child was still-born or survived her birth and died later ("the jurisdiction issue"). Secondly, whether the Coroner was right to deny anonymity to the mother of the child and members of her family ("the anonymity issue"). Permission to apply for judicial review of the Coroner's decision to assume jurisdiction was granted by Kerr J. He refused permission on the anonymity issue. Permission was granted by Laws LJ when considering the claimant's application for permission to appeal against that refusal. He directed that the substantive judicial review should be heard in the Court of Appeal. We shall continue to refer to the child's mother as the claimant.

2. At the conclusion of the argument we announced our decision on the jurisdiction issue. We concluded that the Coroner has power to investigate and hold an inquest to determine whether the child was born alive and, if so, how she came by her death. On the second issue we have concluded that the decision to refuse anonymity was correct.

The Facts

The initial account given by the claimant

3. In the morning of Tuesday 5 March 2013, the claimant, and her mother, attended the Accident and Emergency Department of Airedale General Hospital, Keighley. They brought with them a shoebox containing the body of a baby girl. It was clear that death had occurred sometime before. No attempt at resuscitation was made. The police were called.

4. The claimant was born in 1994 and was then nineteen years old. Her account to the hospital, and to the first police officers attending, was that she had been raped some time before, and her pregnancy had resulted from the rape. She had not had any consensual sexual relations. She had concealed the pregnancy from her family by wearing baggy clothing. On the night of Tuesday 26 February 2013, the claimant had gone into labour alone in her bedroom. The child was born in the early hours of Wednesday 27 February 2013. We should make it clear that we use the terms "child" or "baby" for simplicity's sake. They imply no conclusion as to whether this was a live birth or a still-birth.

5. The claimant told no one and summoned no help. She said at that stage the child did not cry or make any noise. She did not look to see if it was a girl or a boy. She did not want to touch the child, and did not check for a pulse or whether the child was breathing. She placed the child in a square-shaped shoe box and placed it under her bed. She put the soiled bedclothes in bin bags, and later into the bin outside the house.

6. The claimant and her mother both said she told the family nothing, initially. During Saturday 2 March 2013, the claimant's mother noticed a bad smell in the bedroom. Her mother discovered soiled bedding in the room, and then discovered the baby. The claimant told her mother she had been raped. The claimant's mother put the body into the boot of her car. Neither of the women told anyone else in the family.

7. The claimant was unwell. Her mother tried to arrange an appointment with the family GP on Monday 4 March 2013, but that was unsuccessful. As a result, they went to hospital on the Tuesday morning, carrying the body in the box.

8. Once medical and nursing staff were aware of the child's body and the initial story, the police were alerted, and both women gave their first accounts as above. The claimant was in need of a blood transfusion and remained in hospital for two days.

The post mortem and the conclusion of the pathologists

9. On the morning of Wednesday 6 March 2013, a post mortem examination was conducted jointly by Dr Kirsten Hope FRC Path, forensic pathologist, and Dr Jens Stahlschmidt FRC Path, paediatric pathologist. The "appearances were those of a full term female baby, with no obvious congenital abnormality". There were no signs of injury. The findings of the pathologists were that there was no evidence of natural disease, or of trauma. The baby had grown normally for term gestation. There was no evidence of congenital disease, or infection. There was no sign suggesting prolonged intra-uterine death. The respiratory tract and stomach did not contain meconium, the presence of which can be a sign of stress in the womb or during birth. The condition of the placenta pointed to neither a live birth nor a still-birth. Findings in the lungs showed they had been expanded. This is consistent with breathing, but could be produced by gas as an effect of infection or putrefaction after death.

10. The brain was submitted for specialist examination by Dr Assam Ismail, consultant neuropathologist. The findings of the neuropathologist were that the brain was structurally normal, with no "contusion, malformation or any other lesion". There was no sign of bleeding, stroke, inflammation, malformation "or any other pathological features". There was widespread cerebral congestion, which is a "non-specific" finding, consistent with hypoxia-ischaemia, or with other disorders, or as an early sign of head injury.

11. The examining pathologists reported in July 2013, once the neuropathological findings were available to them. Their joint conclusions read:

> "In conclusion, no natural disease process has been identified and there were no injuries which could explain death. Therefore, the cause of death is best regarded as being unascertained. The post-mortem examination has demonstrated no reason why this infant could not have been born alive and there are some pathological features to suggest that it may have breathed independently, although if it did, the pathology cannot demonstrate whether or not this occurred when it was completely expelled from the mother. There are several factors which may have led to a lack of oxygen (asphyxia) to the body. These include birth asphyxia which is the failure to establish

> regular breathing at birth or suffocation which was accidental or otherwise."

The claimant's subsequent account

12. The claimant was first formally interviewed on Tuesday 12 March 2013, five days after her discharge from hospital. She gave a detailed account of her alleged rape which she said had occurred at the end of May 2012, describing the circumstances, including the two men she alleged had raped her in an alleyway after she left a youth club. The police mounted an investigation, including taking DNA samples from [the claimant] and the child. By 19 March 2013, the police investigation had led to a man from whom a DNA sample was taken.

13. That young man was seen by police on 2 July 2013. He gave an account of a consensual, but clandestine, sexual relationship with the claimant. He said the relationship had ceased many months before. He had no idea she was pregnant or had given birth.

14. The claimant was re-interviewed on the same day. At first she maintained that she had been raped, at the same time conceding that she had also been in a consensual sexual relationship. After a break in the interview, she agreed that the story of a rape was untrue. She had made up the story when revealing the baby to her mother. She was then taken once more through the events of the birth. She said the baby "felt cold" when it was born. She denied putting bedding over the child's face. It did not look alive when she put it in the shoe box.

The application for anonymity

15. Turning to the evidence relevant to the application for anonymity, it will be clear that irrespective of any specific religious or cultural context, the primary facts would be difficult and embarrassing for any family. The claimant seeks to put the matter higher than that.

16. As indicated above, the claimant concealed matters from anyone until her mother discovered the baby, and then they kept matters from other members of the family. In discussion with the police, the claimant's mother specifically stated that she did not want her husband to know. She did not make any specific claims as to the consequences, if he were to discover the truth.

17. The Crown Prosecution Service reached the view that:

> "there was insufficient evidence to charge any person with any criminal offences in this case ... The difficulty regarding homicide offences lay in the fact that it could [sic] be established if the baby was alive or not."

18. On 18 August 2014, an investigation was opened in public by an Assistant Coroner. The claimant's case is that she was unaware that the hearing was taking place and did not attend. No direction was sought or made to protect her identity. She was named in the hearing, and a number of the circumstances were outlined regarding the birth. The hearing was adjourned pending further investigation.

19. Later that day, the local *Telegraph and Argus* newspaper published a report of the case, summarising the facts, naming the claimant, and indicating that she had lived in her home area of Keighley. This report was placed on the internet and has remained accessible there ever since.

20. The Coroner took office on 1 December 2014. An inquest hearing was scheduled for 10 February 2015. In late December 2014 the claimant's solicitors indicated (*inter alia*) they would seek an order anonymising the claimant and her family and reporting restrictions under s.11 of the Contempt of Court Act 1981. These applications were made principally on the basis that reporting would expose her to risks of harm and ostracism within her community. It was opposed by Newsquest Media Group, the publishers of a number of regional newspapers including the *Telegraph and Argus.* A pre-inquest hearing was fixed for 5 February 2015. Written submissions were made thereafter, including a detailed submission from the publishers of the *Telegraph and Argus.* A further preliminary hearing was held on 28 August 2015. The Coroner handed down a written ruling on 18 September 2015.

The evidence relied on by the claimant on the application for anonymity

21. In advance of the hearing, the claimant's solicitors filed three statements from members of her family. They also filed a report from an expert in honour-based abuse, Dr Sanghera CBE, and two letters from the claimant's GP.

22. In her statement the claimant describes how she was given safeguarding protection by the West Yorkshire Police as a precaution. When the family moved away from Keighley to another town, safeguarding was taken over by the new local police force. In this witness statement the claimant says "my father and siblings don't know fully what happened". She indicated that if she had stayed in Keighley she would have been "really scared" as she would have been living in fear that:

> "... a member of my family would find out and not knowing if they would do something to harm me. I have a lot of immediate family who live in Keighley and they are not nice people. If they were to find out, they would most definitely harm me or ensure I go to Pakistan to get married because in their view I will have brought shame on the family."

23. The claimant also states that following the opening of the inquest in August 2014 and the report in the media, she got a number of text messages. She found it extremely difficult to read them. They were abusive. She went on to say:

> "In particular one member of the family who is not very nice, sent me a text message saying I had brought shame on the family and that if she ever saw me again she would kill me."

The claimant says that text messages persisted and she ceased to read them, turned off her phone, changed her telephone number within days "and so did the rest of my family". She says she did not keep any text messages and deleted her Facebook account. She did not go to the police "because I was scared it would make things worse and even more things would get out".

24. The claimant has never produced any corroborating evidence of the abusive text messages and has not identified the senders.

25. The second statement is from the claimant's aunt. It is very similar in content. She, too, claims that the extended family "are not very nice people". She describes the local reporting in Keighley as "relatively contained". The reports did not reach the local press elsewhere and "most importantly has not been picked up by the Asian press". She expresses a fear that the community will wish to "ensure [the claimant] is taught a lesson" partly to demonstrate to the community that such behaviour is not tolerated. She emphasises that the shame which will arise is not just a shame on the claimant but on the broader family connected with her. Their reaction will be severe punishment:

> "There is nothing I or [the claimant]'s mum could do to protect her from the community if it gets out more widely. I can say almost with certainty that as a minimum [the claimant] would be taken to Pakistan and married off by whatever means it would take to do this."

Who would do this is not identified.

26. The third statement is from the claimant's mother. She, too, says that the claimant's "father or siblings don't know the full extent of what happened". She says that she too received hostile text messages following the opening of the inquest. If there was further publicity, those who live around them would learn what happened and "[the claimant]'s father would most definitely know the full details of what happened". She says the claimant would be dishonoured and she is fearful there could be a real threat of abduction and forced marriage.

27. The report from Dr Sanghera is necessarily relatively generalised and drawn from the case papers. She has never met the claimant or been able to interview any family member. She was therefore able only to describe what can and has happened in other examples. She did describe the fact that there have been some very severe cases of episodes of family shaming, including honour killings, abductions and forced marriages.

28. Dr Sanghera formed the view that the claimant's father will "be aware of the circumstances linked to his daughter and the issues of shame". She did say that "further reporting which could lead to greater knowledge from within the family, extended family and broader communities will increase the family's motives to contain the shame ... I do not have enough knowledge about this family to form an in-depth assessment...".

29. Dr Sanghera addressed the question of safeguarding, concluding that:

> "It is not unrealistic for a multi-agency safeguarding team to protect [the claimant] with her active engagement. I would advise that the safeguarding team conduct a specific honour-based risk assessment that is able to identify codes of honour and the risks to inform safeguarding strategies and a safeguarding plan. Karma Nirvana has developed a National

> Police Risk Assessment Tool that is currently being implemented nationally."

Dr Sanghera also considered that a Forced Marriage Protection Order could be considered, especially as the fears of both mother and aunt reinforce this as a credible threat.

30. The other evidence relied upon are the two letters from the GP practice in the town to which the claimant has moved. The first letter (dated 2 February 2015) recorded that, although the claimant had a depressed mood, she had never spoken of the birth; the practice only knew of it from the medical records. The second letter (dated 2 September 2015) from the GP practice made clear she was no longer on anti-depressants.

31. Also before the Coroner was a letter from West Yorkshire Police, Bradford South Safeguarding Unit, dated 23 January 2015. This made it clear that safeguarding was not a response to any specific information or intelligence that the claimant was at risk. The safeguarding measures were "purely precautionary". The claimant and her mother had a series of face-to-face meetings, were given advice on safety and direct contact numbers for a safeguarding "single point of contact officer". Social Services were involved to ensure there was no risk to other children in the family. A "community impact assessment" was put in place with briefing from various sources. The safeguarding was monitored on a repeat basis and the threat and risk was continually reviewed. Finally, the unit confirmed that when the family relocated from Keighley, staff from the Bradford South Safeguarding Unit held a meeting with colleagues to hand over the process.

32. It was against the backdrop of that evidence that the Coroner reached his decision refusing an order for anonymity.

The Jurisdiction Issue

The Statutory Scheme

33. S.1 of the Coroners and Justice Act 2009 ["the 2009 Act"] provides:

> "Duty to investigate certain deaths
>
> (1) A senior coroner who is made aware that the body of a deceased person is within the coroner's area must as soon as practicable conduct an investigation into the person's death if subsection (2) applies.
>
> (2) This subsection applies if the coroner has reason to suspect that –
>
> (a) the deceased died a violent or unnatural death,
>
> (b) the cause of death is unknown, or
>
> (c) the deceased died while in custody or otherwise in detention.

(3) Subsection (1) is subject to sections 2 to 4.

(4) A senior coroner who has reason to believe that –

(a) a death has occurred in or near the coroner's area,

(b) the circumstances of the death are such that there should be an investigation into it, and

(c) the duty to conduct an investigation into the death under subsection (1) does not arise because of the destruction, loss or absence of the body,

may report the matter to the Chief Coroner.

(5) On receiving a report under subsection (4) the Chief Coroner may direct a senior coroner ... to conduct an investigation into the death.

(6) ...

(7) A senior coroner may make whatever enquiries seem necessary in order to decide –

(a) whether the duty under subsection (1) arises;

(b) whether the power under subsection (4) arises.

(8) ..."

S.6 requires a coroner to hold an inquest as part of an investigation unless one of a number of reasons identified in the 2009 Act for discontinuing an investigation after its commencement applies.

34. S.14 of the 2009 Act concerns post-mortem examinations:

"(1) A senior coroner may request a suitable practitioner to make a post-mortem examination of a body if-

(a) the coroner is responsible for conducting an investigation under this part into the death of the person in question, or

(b) a post-mortem examination is necessary to enable the coroner to decide whether the death is one into which the coroner has a duty under section 1(1) to conduct an investigation."

35. The explanatory notes relating to s.14 include the following:

"134. This section sets out the arrangements for ordering post-mortem examinations, and makes slightly different provision

from that contained in sections 19 and 20 of the [Coroners Act 1988].

135. Subsection (1) gives a senior coroner power to ask a suitable practitioner to make a post-mortem examination of the body if the senior coroner is either responsible for conducting an investigation into the death or a post-mortem examination will enable the senior coroner to decide if he or she has a duty under section 1 to conduct an investigation. This may be relevant where it is not clear whether a death occurred as a result of a notifiable disease or whether a child was stillborn – where, for example, an infant's body is found and it is not clear whether it ever had independent life. Where it is known or established that the child was stillborn, the senior coroner will have no further power to carry out an investigation."

36. The provisions of the 2009 Act came into force on 25 July 2013. Baby T was born at the end of February 2013 and the post-mortem examinations were conducted in March of that year. At that time the Coroner (strictly his predecessor) was acting under powers conferred by the Coroners Act 1988. S.8(1) provided:

> "Where a coroner is informed that the body of a person ("the deceased") is lying within his district and there is reasonable cause to suspect that the deceased –
>
> (a) has died a violent or an unnatural death;
>
> (b) has died a sudden death of which the cause is unknown; or
>
> (c) has died in prison or in such a place or in such circumstances as to require an inquest under any other Act,
>
> then, whether the cause of death arose within his district or not, the coroner shall as soon as practicable hold an inquest into the death of the deceased either with or ... without a jury."

The Coroners Act 1988 consolidated earlier legislation, including the Coroners Act 1887 ["the 1887 Act"], which in s.3(1) had a provision to the same effect:

> "Where a coroner is informed that the dead body of a person is lying within his jurisdiction, and there is reasonable cause to suspect that such person has died either a violent or an unnatural death, or has died a sudden death of which the cause is unknown, or that such a person has died in prison, or in such place or under such circumstances as to require an inquest in pursuance of any Act, the coroner, whether the cause of death arose within his jurisdiction or not, shall, as soon as practicable issue his warrant for summoning [jurors] ... there to inquire as jurors touching the death of such person as aforesaid."

37. The "slightly different" provisions in the 1988 Act relating to post-mortem examinations, referred to in the explanatory notes to s.14 of the 2009 Act, included s.19. That provided:

> "(1) Where a coroner is informed that the body of a person is lying within his district and there is reasonable cause to suspect that the person has died a sudden death of which the cause is unknown, the coroner may, if he is of the opinion that a post-mortem examination may prove an inquest to be unnecessary –
>
> (a) direct any legally qualified medical practitioner whom, if an inquest were held, he would be entitled to summon as a medical witness ...
>
> (b) request any other legally qualified medical practitioner,
>
> to make a post-mortem examination of the body and to report the result of the examination to the coroner in writing."

The Coroner's Conclusions

38. The Coroner produced a detailed and impressive written ruling dated 18 September 2015 following an earlier oral hearing and the submission of extensive written argument. In addition to the statutory provisions of the 2009 Act to which we have referred, he noted the definition of a still-born child found in s.41 of the Births and Deaths Registration Act 1953, namely "a child which has issued forth from its mother after the twenty-fourth week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any other signs of life." He accepted the argument that for the purposes of s.1 of the 2009 Act neither a child which is still-born nor a foetus which has died can be regarded as a "deceased person". That was because the destruction of a foetus in the womb is not a homicide (see *AG's Reference (No 3 of 1994)* [1998] AC 245 at 254 A – D). Moreover, the common law affords no independent rights to a foetus (see *Re MB (An Adult: Medical Treatment)* [1997] 2 FCR 541 at [38] to [46]). He rejected the argument that s.1(1) of the 2009 Act required the coroner to determine as a precedent fact on the balance of probability that the baby was born alive and concluded that subsection (1) had to be read with subsection (2). That sets a low threshold for investigation in recognition that it is only after evidence has been heard that a conclusion can be reached. He added:

> "It would be inconsistent with [the] legislative purpose if subsection (1) were read as importing a further test which had to be satisfied to a higher standard and which could be equally difficult to satisfy as a matter of evidence in a case such as the present. ... If the argument of those representing [the claimant] were right, a coroner could be placed in the impossible position of having to decide an important issue on the balance of probabilities without having the powers under Schedule 5 to the [2009 Act] to gather evidence and call witnesses. Those powers are engaged only when a coroner has commenced an

> investigation. The present case affords a good example. It is my view that it will only be when I have examined both [the claimant] about the circumstances and aftermath of the delivery and the pathologists about their findings and deductions, that I will be able to make a properly informed conclusion as to whether or not Baby T was born alive."

Submissions

39. Mr Cragg QC who appeared on behalf of the claimant submitted that the statutory scheme of the 2009 Act precludes a coroner from commencing an investigation into the death of child, including holding an inquest, unless before that formal investigation begins the coroner is able to say that the child was probably born alive, rather than stillborn. The coroner may make the preliminary enquiries envisaged for that purpose by s.1(7). That conclusion flows from the language of s.1(1) because the power to investigate attaches only if there is "the body of a deceased person" in the area. There can only be the body of a deceased person if (a) that person was born alive and (b) subsequently died. He submitted that the coroner cannot hold an inquest or use any of the coercive powers provided by the 2009 Act to obtain evidence as to the circumstances of the birth. He accepted that an inquest may be held into the death of a child who the coroner, on preliminary inquiry, has determined was probably born alive. At that inquest the preliminary view may be confirmed, in which case details of who the child was, and where, when and how he came by his death will be recorded in accordance with s.5, following a full exploration of the evidence. Alternatively, the evidence may confound the earlier conclusion in which case a conclusion of "still-birth" will be recorded. We observe that such a conclusion is expressly provided for in the Coroners (Inquests) Rules 2013, which came into force on the same day as the 2013 Act. They repeated a like provision in the Coroners Rules 1984 and the Coroners Rules 1953. Mr Cragg submitted that if a coroner is unable to conclude that the child was probably born alive following the preliminary inquiries, that is the end of the matter even if, as must inevitably be the case, there will be instances where a full exploration of the evidence at an inquest would have confirmed that the child was in fact born alive and died in circumstances that otherwise would have been investigated and resulted in a formal conclusion at the end of an inquest.

40. The effect of Mr Cragg's submission is to require a coroner to determine as a preliminary issue on incomplete evidence one of the very matters he would be required to determine on full evidence at an inquest, namely whether the child was born alive. He submitted that is the inescapable effect of the statutory scheme, despite the consequence that the death of a child in fact born alive may well go undetected and unrecorded.

41. Ms Richards QC on behalf of the Coroner submitted that the Coroner was right on the jurisdiction issue for the reasons he gave. She emphasised that s.14 envisages a post-mortem examination being carried out on a body which may turn out not to be that of a deceased person. She prayed in aid the oddity of interpreting the statute in a way which deprives a coroner of the opportunity to discover whether a child was born alive and may have died in circumstances which properly call for scrutiny.

Discussion

42. We are satisfied that the Coroner was correct to conclude that the 2009 Act enables a coroner to open an investigation into whether a baby was born alive, or still-born, without first having to be satisfied on information gathered before he opens the investigation that the child was probably born alive. The statutory scheme as a whole, read with the purpose in mind of an investigation and inquest, is to that effect. The narrow construction contended for by the claimant, in addition to delivering what we regard as a nonsensical result, is inconsistent with other provisions of the 2009 Act and its predecessors.

43. The language used in s.1 of the 2009 Act echoes that found in both the 1988 and 1887 Acts. Whilst the language has varied to reflect the style of legislative drafting over time, the underlying jurisdiction of a coroner in respect to a child that may have been born alive or still-born has not changed since 1887. The 1887 Act was itself an act to consolidate the law relating to coroners. Still-birth is a tragedy that continues to befall many families in advanced societies but it was a phenomenon more common in the past. More such cases would have come to the attention of Victorian coroners than now. The public interest in establishing whether a child was or was not still-born, and if it was not how it came by its death, is apparent and continuing.

44. Past editions of *Jervis on Coroners* make clear that in the case concerning the body of an apparently new-born child, a question for consideration at an inquest would be whether it was born alive or was still-born. There is no hint of any suggestion that the coroner was obliged on preliminary information to come to a provisional conclusion on balance of probabilities that the child was born alive before embarking upon an investigation or holding an inquest. Only if the evidence at the inquest supported the conclusion that the child was born alive would the inquest be concerned with the questions of cause of death and any criminal liability for the death. Establishing criminal liability, with the coroner's inquisition acting as an indictment for murder, manslaughter (and later, infanticide), was a central function of an inquest. The first edition (1829), second edition (1854) and third edition (1866) all made clear that, when dealing with the dead body of a child "the first question which naturally presents itself is, whether the child was born alive." - see, for example, page 160 of the third edition. An appendix to those editions contained forms and precedents which provided for a conclusion that a child was still-born, in which case there would be no further consideration of a cause of death. The fourth edition of 1880, the fifth of 1888 (which updated the work to take into account the passage of the 1887 Act) and the sixth of 1898 were to the same effect.

45. The 7th edition of 1927, which followed the enactment of the Infanticide Act 1922, and changes to the statutory regime governing the registration of deaths, was in similar vein. At page 159 it said:

> "The first question to be determined, however, is whether the child was born alive; firstly, whether the dead body was that of a viable child; secondly, if it had ever breathed; and, thirdly, if it was born alive in a legal sense. ... After July 1, 1927, 'still-births' must be registered by the coroner, if such a verdict is so found at an inquest."

46. The eighth edition of 1946, at pages 49 to 50, made the point that a still-born child "cannot be the subject of a completed inquest" and that

> "if an inquest be opened upon a body and it turns out to be that of a still born child, though there can be no verdict as to the cause of death, the coroner nonetheless does transmit to the registrar of deaths a certificate setting out the facts so far as they are known."

47. It was in this way that the question whether a child was still-born was treated as a preliminary issue at an inquest. The same formulation appears in the ninth edition of 1957 with additional guidance to coroners on how the printed forms should be amended to make clear that the inquest was conducted on the body of a still-born child.

48. S.5 of the Births and Deaths Registration Act 1926 as originally enacted provided:

> "It shall not be lawful for a person who has control over or ordinarily buries bodies in any burial ground to permit to be buried or to bury in such burial ground a still-born child before there is delivered to him either a certificate given by the registrar under the provisions of this Act relating to still-births or, if there has been an inquest an order of a coroner."

49. A still-birth must now be reported and registered under s.1(1) of the Births and Deaths Registration Act 1953 ["the 1953 Act"]. Most cases of still-birth will be reported to the registrar and registered without controversy. However, by regulation 33 of the Registration of Births and Deaths Regulations 1987, a registrar must refer to the coroner an alleged still-birth if he has reason to believe that the child was born alive. Further regulations provide for the registration of a still-birth if the coroner decides not to hold an inquest (in practice following a post-mortem examination), or after an inquest, if that is the conclusion recorded. Different parts of the regulations cover the registration of the death if, amongst the conclusions at the inquest, is one that the child was born alive. The provisions of s.5 of the earlier 1926 Act were first amended to reflect the changes brought about by the 1953 Act. But s.5 was further amended by Schedule 21 to the 2009 Act, with the amendment coming into force on the same day as that Act:

> "In section 5 (burial of still-born children), for the words after "delivered to him" substitute "either–
>
> (a) a certificate given by the registrar under section 11(2) or (3) of the Births and Deaths Registration Act 1953, or
>
> (b) in a case in relation to which a senior coroner has made enquiries under section 1(7) of the Coroners and Justice Act 2009 (or has purported to conduct an investigation under Part 1 of that Act), an order of the coroner."

50. This provision contemplates that following inquiries under s.1(7) a coroner may be satisfied that a child was still-born. Further, it contemplates that if the coroner is not

so satisfied the coroner will go on to conduct an investigation. The use of the word "purported" keeps the 2009 Act in line with the previous law. A coroner has jurisdiction to inquire into the death of a child where the circumstances of its birth give rise to reasonable suspicion that it was born alive and died in circumstances which call for an investigation. The coroner has power to gather whatever evidence is necessary to determine the issue, whether as an inquiry, as part of an investigation or investigation which includes an inquest.

51. There is undoubtedly power under s.14 to order a post-mortem examination on a body to determine whether "the death" of a child was or was not a still-birth. The explanatory notes make that clear but, in our judgment, the provision continues a power which has long existed and was contemplated within the similar provisions in both the 1988 and 1887 Acts, ss.19 and 21 respectively. That last provision enabled the coroner to order a post-mortem examination on the "body of the deceased" in an historical echo of the formulation in s.1 of the 2009 Act. The statutory language of "body of a person" in s.19 of the 1988 Act and "body" coupled with "death" in s.14 of the 2009 Act also encompasses the body of a child who might have been born alive but may have been still-born, for the purpose of ordering a post-mortem.

52. The various formulations in the statutes which have conferred on a coroner jurisdiction to investigate a death are to like effect. The foundation of the jurisdiction of a coroner has long been the presence of a body within his geographical area coupled with the grounds for suspicion or belief that a death was not natural or occurred in custody. The coroner's duty arose on being "informed" of the presence of a body or, now under the 2009 Act being "made aware" of a body. In s.1(1) of the 2009 Act the term "body of a deceased person" encompasses the body of a child who might (or might not) have been born alive. The same was true of the formulation in the 1988 Act – "body of a person ("the deceased")" and the 1887 Act – "dead body of a person". There is no difficulty in construing these provisions in a way which enables the coroner to determine whether he is in fact dealing with the body of a person who has lived. To do otherwise would be to undermine the rationale of the legislation, namely to investigate suspected non-natural deaths.

53. This interpretation is of a piece with s.1(4) of the 2009 Act. That contemplates an investigation "into the death" in circumstances where a coroner has "reason to believe that a death has occurred" in or near his area but where there is no body. That might, for example, be because of a suspected drowning or the suspected destruction of a body in a fire. In neither case does the statute require a prior conclusion on the balance of probabilities that someone has in fact died before "the death" can be investigated. This provision has its antecedents in the 1988 Act and the Coroners (Amendment) Act 1926, ss.15 and 18 respectively. In such cases one of the purposes of the investigation will be to determine whether someone has in fact died. That is a proper area of investigation: see *R v Home Secretary ex parte Weatherhead* (1996) 32 BMLR 72. Mr Cragg accepted that in this provision the word "death" is used in a way which does not require the pre-determination on balance of probabilities that someone has in fact died. In the case of a baby who may have been born alive or may have been still-born, the interpretation of s.1 in the way he advances on behalf of the claimant would produce an immediately anomalous result. The body of Baby T was recovered in the shoe box and it is said there can be no investigation under s.1 of the 2009 Act because the post-mortem examinations were inconclusive on the

question whether she lived outside her mother. Had the body been disposed of and lost or destroyed there could be an investigation, on the basis of grounds to suspect she might have lived.

54. A consideration of all the statutory provisions, in the light of the historical position described in successive editions of *Jervis on Coroners,* leads to the conclusion that a coroner can investigate the death of a baby who may have been born alive or may have been still-born without first being satisfied on balance of probability that it was born alive, so long as he suspects one of the matters set out in s.1(2) is in play. The question whether there was a death is a component of the matters which may be the subject of suspicion.

The anonymity issue

The applicable legal principles

55. There can be little doubt as to the applicable principles. At issue in the appeal is the fact-sensitive application of those principles to the claimant's application. The principles can therefore be briefly summarised.

56. Open justice is the fundamental principle in respect of all proceedings before any court, including coroners' courts. The principle has been expressed in numerous cases, including *Scott v Scott* [1913] AC 417 (see the judgments of Viscount Haldane LC at 437-9 and Lord Shaw said at 476-8) and *Attorney-General v Leveller Magazine* [1979] A.C. 440 where Lord Diplock summarised the principle at 449-450:

> "As a general rule the English system of administering justice does require that it be done in public: *Scott v Scott* [1913] A.C. 417. If the way that courts behave cannot be hidden from the public ear and eye this provides a safeguard against judicial arbitrariness or idiosyncrasy and maintains the public confidence in the administration of justice."

57. This principle applies to coroners' courts: see *R (A) v HM Coroner for Inner South London* [2004] EWCA Civ. 1439 at [20]. It is further embodied in Rule 17 of the Coroners Rules 1984 (now Rule 11 of the Coroners (Inquests) Rules 2013).

58. One very important aspect of the principle of open justice is the naming of those before the court. As Lord Rodger said in *Re Guardian News and Media Ltd* [2010] 2 A.C. 697 at [63]:

> "What's in a name? 'A lot', the press would answer. This is because stories about particular individuals are simply much more attractive to readers than stories about unidentified people. It is just human nature... A requirement to report [a story] in some austere, abstract form, devoid of much of its human interest, could well mean that the report would not be read and the information would not be passed on."

59. Any restriction on the principle of open justice, including the making of an order for anonymity, requires cogent justification: see for example, *Attorney-General v*

Leveller Magazine [1979] A.C. 440 at 450. It is common ground that the coroner's power to manage inquest proceedings, includes the power to make an order for anonymity of witnesses and others: *R (A) v HM Coroner for Inner South London.* A coroner also has power under s.11 of the Contempt of Court Act 1981 to impose reporting restrictions:

> "In any case where a court (having power to do so) allows a name or other matter to be withheld from the public in proceedings before the court, the court may give such directions prohibiting the publication of that name or matter in connection with the proceedings as appear to the court to be necessary for the purpose for which it was so withheld."

However, the exercise of these powers requires justification for the departure from the principle of open justice.

60. The first justification relied on by the claimant was a real and immediate threat to her life within Article 2 of the European Convention on Human Rights ("ECHR") if the order for anonymity was not granted. The principles applicable to this were elucidated in in *Re Officer L* [2007] 1 WLR 2135 in the judgment of Lord Carswell. He said at [20]:

> "The wording of this test has been the subject of some critical discussion, but its meaning has been aptly summarised in Northern Ireland by Weatherup J in *In re W's Application* [2004] NIQB 67, at [17], where he said that 'a real risk is one that is objectively verified and an immediate risk is one that is present and continuing'. It is in my opinion clear that the criterion is and should be one that is not readily satisfied: in other words, the threshold is high."

61. The second justification relied on by the claimant was a real and immediate risk of inhuman and degrading treatment to her under Article 3 of the ECHR. In *Secretary of State for the Home Department v AP* [2010] 1 WLR 1652, Lord Rodger in a judgment (with which the other members of the Supreme Court agreed) accepted (at [14]) in the unusual circumstances of that particular case that the putting at risk of physical violence might amount to an infringement of the Article 3 rights of AP . However, in that case it would appear that the risk arose from the fact that the state had used a control order to locate AP in a town where those risks would arise.

62. The third justification relied on by the claimant was her rights under Article 8. In such a case the court has to conduct a balancing exercise which takes into account the rights of the media under Article 10: see the judgment of Lord Steyn in *Re S (A Child)* at [16] and [17], as summarised in *Re Guardian News and Media Ltd* [2010] 2 A.C. 697 and *Secretary of State for the Home Department v AP (No. 2)* [2010] 1 WLR 1652 at [7]:

> "the court must ask itself 'whether there is sufficient general, public interest in publishing a report of the proceedings which identifies [AP] to justify any resulting curtailment of his right and his family's right to respect for their private and family life'."

63. The balancing exercise is highly fact specific. It must take into account the evaluation of the purpose of the principle of open justice as applied to the facts of the case and the potential value of the information in question in advancing that purpose, as against the risk of harm the disclosure might cause the maintenance of an effective judicial process or to the legitimate interests of others: see the appeal from the Court of Session in *A v BBC* [2015] AC 588 at [34] – [41] and [46] – [57]. In *R (C) v Secretary of State for Justice* [2016] 1 WLR 444, the case involved a mental patient compulsorily detained under a hospital order made by a criminal court under s.37 and s.41 of the Mental Health Act 1983. The passage in the judgment of Lord Rodger in *Re Guardian News and Media Ltd.* (which we have set out at paragraph 58 above) was expressly affirmed by Baroness Hale, though this decision depended on a fact sensitive analysis of all the considerations, including the long standing anonymity given to those suffering from a mental disorder.

64. A fourth justification relied on by the claimant, as an alternative to Articles 2, 3 and 8, was the common law duty of fairness: see *Re Officer L* at [22]. A wide range of factors must be brought into account. However, such considerations must be weighed against other common law considerations, including the powerful imperative of open justice.

The Coroner's Conclusions

65. The second part of the Ruling of 18 September 2015 in which the Coroner set out his conclusions on anonymity and reporting restrictions was equally as impressive as the part relating to jurisdiction which we have summarised at paragraph 38 above. After setting out the applicable principles, the Coroner noted that no argument was advanced to him that anonymity was necessary to protect the claimant from a real and immediate risk of death. Accordingly Article 2 rights could not arise. However, the claimant's rights under Article 8 were clearly engaged; an anonymity order might "very well reduce her exposure to humiliation and abuse." The prospect of the claimant suffering actual harm was highly speculative; there was no firm basis for saying that she might face retaliatory action in the future. Any order imposing anonymity would interfere with the Article 10 rights of the media and infringe the principle of open justice, without protecting the claimant as she had been named in reports (to which we have referred at paragraph 19) which remained accessible.

66. The Coroner highlighted three factors in the balancing exercise. First, the claimant had already been named in reports that remained accessible by internet search, meaning that an anonymity order could not provide complete protection to her reputation. Secondly he voiced particular concern that the evidence that the claimant would suffer actual harm if named in court was highly speculative:

> "Since the earlier hearing and the press reporting, she has suffered upsetting abuse but has not faced any retaliatory actions as such. There is no firm or specific basis for saying that she might face such action in future. In this respect, it is noteworthy that the local safeguarding team of West Yorkshire Police said about her situation in a letter dated 23 January 2015 [to which we have referred at paragraph 31 above]:

> 'There was no specific information or intelligence that she was at risk from her family or the local community; the safeguarding measures were purely precautionary.'"

67. Thirdly, the Coroner set out the alternative measures he could take (and which he ordered be taken) to give some measure of protection to the claimant, including (a) the use of a screen while she gave evidence; (b) the making of practical arrangements to prevent her being seen or photographed in the environs of the court; and (c) the exclusion of questions or evidence as to where she and her family now live. He therefore concluded that the factors militating against anonymity outweighed those in favour.

Submissions

68. Mr Cragg QC submitted that the Coroner's statement that there had been no argument regarding a real and immediate risk of death for the purposes of Article 2 was made in error, as the claimant's solicitors had relied on both Article 2 and Article 3 and made no concession in respect of this submission. The evidence before the Coroner, particularly (a) the witness statements of the claimant, her mother and her aunt and (b) the expert report of Dr Sanghera, were clearly sufficient to verify an immediate, present and continuing risk to life under Article 2. In the alternative the same evidence demonstrated that a failure to grant anonymity would materially increase the risk to the claimant.

69. Mr Cragg also argued that the Coroner's failure explicitly to address Article 3 in his ruling was of great significance. That was because the range of harm that could engage Article 3 might fall short of a risk of death and include abuse, humiliation and forced marriage. Moreover, Article 3 might be engaged by a mere possibility of a risk of harm: *A v BBC* [2015] AC 588. This might be the case even where an applicant was unable to provide evidence of any actual threat faced: *Secretary of State for the Home Department v AP (No. 2)* [2010] 1 WLR 1652. The Coroner should have held that the evidence was sufficient for the purposes of Article 3 to mandate anonymity.

70. Mr Cragg next submitted that the interference with the claimant's right to respect for her private life under Article 8 was sufficient to outweigh the Article 10 rights of the media. The Coroner's approach to balancing the rights was flawed. He failed properly to examine the claimant's circumstances in evaluating the extent of interference with her Article 8 rights; there was a corresponding failure to analyse the extent of the public interest in publishing the claimant's identity. This was particularly important in the context of the coronial jurisdiction where, unlike the criminal jurisdiction, proceedings were not concerned with culpability or imparting blame. The public interest in publication was therefore necessarily reduced. An order for anonymity should be made at least until it was established that there was a live birth. The continued existence of material on the internet identifying the claimant would not provide an adequate justification for refusing anonymity. Further publication in the national media would undoubtedly increase the degree of intrusion into her private life: *PJS v News Group Newspapers* [2016] UKSC 26; [2016] A.C. 1081 at [29].

71. Mr Cragg also submitted that the Coroner had failed explicitly to analyse the application for anonymity in terms of the common law duty to act fairly, and the lack of regard paid to the claimant's subjective fears.

72. Ms Richards QC submitted that the Coroner directed himself correctly on the legal test. He gave full and proper consideration to all the evidence and was entitled to conclude that it fell well short of the threshold required to engage Articles 2 or 3. The failure to make an express reference to Article 3 was immaterial; the substance of the issue was properly addressed by the Coroner. The balancing exercise under Articles 8 and 10 and under the common law was carried out carefully and entirely free from any error of law.

Discussion

73. We are entirely satisfied that the Coroner gave due consideration to all the evidence put before him and was entitled to refuse an order for anonymity.

74. The first ground on which it was said there should be a departure from the principle of open justice was that there was a real and immediate threat to life under Article 2. As we have set out at paragraph 60, the threshold is a high one. The evidence before the Coroner did not begin to establish what was required; there was simply no evidential basis for any reliance on Article 2. Although the witness statements (which we have summarised at paragraphs 22 and following) referred to the receipt of some unpleasant text messages, the senders of the alleged threatening text messages were never identified; neither the claimant nor her aunt nor her mother reported the messages to the police or provided them to the police. The claimant deleted them. The letter from the police which we have summarised at paragraph 31 made clear there was no specific intelligence that she was at risk from either the community or her family; the safeguarding measures were purely precautionary. In any event she now lived in a different area.

75. Nor did the expert report provide assistance. Dr Sanghera did not meet the claimant or interview family members and her conclusions were necessarily generalised.

76. As to the second ground, the alleged interference with the claimant's Article 3 rights, we will proceed on the assumption that a threat of physical violence can give rise to violation of rights under Article 3. It seems to us that such a violation could not occur unless the violation occurred through actions (or inactions) of a state actor. There were no actions or inactions (in the sense that the authorities would be unable to provide appropriate protection in the face of a credible threat) by anyone on the part of the state in this case which gave rise to any threat of physical violence. There was no evidence to suggest that the naming of the claimant would give rise to such a risk. The earlier publication of her name in the *Telegraph and Argus* (as set out at paragraph 19 above) had given rise to no credible evidence of such a threat. But even assuming that action (or inaction) of a state actor were not required, there was again no evidential basis for any threat of physical violence for the reasons we have already given in respect of Article 2.

77. As to the third ground, the alleged interference with the claimant's Article 8 rights and the effect that publication would have upon them, a balancing exercise was required. The Coroner rightly accepted that the claimant's Article 8 rights were engaged. An order for anonymity would prevent her name being reported and might well reduce the risk of her exposure to humiliation and abuse. However, as regards the extent of that risk, it was right to take account of the fact, as the Coroner did, that she had been identified in the *Telegraph and Argus* and her name could easily be located

by a simple on-line search by anyone wanting to abuse and humiliate her. It was also right to take account of the other measures the Coroner proposed as we have set out at paragraph 67 above.

78. To be balanced against those considerations was first the right of the press freely to report her name for the reasons given by Lord Rodger as set out at paragraph 58 above. Secondly, the facts of this particular case give rise to a significant public interest. The conduct of the claimant was not in any sense a private matter. It was a case quite different to *PJS v Newsgroup Media* [2016] UKSC 26, [2016] A.C. 1081. The claimant was the central actor in what had happened. She had concealed a baby's body for six days and failed to report the birth or still-birth. If the baby was born alive, there would be the further public interest in ascertaining the cause of death. In addition she had made a false allegation of rape against some innocent man which she only admitted after investigation by the police. Quite apart from the general public interest in these matters, the issues that arise are of particular interest and importance to the local communities where the inquest is likely to be reported. In our view, there is a significant public interest in such issues being a subject for public discussion and debate on as fully informed a basis as is possible.

79. Nor can we accept the submission that the coronial jurisdiction gives rise to a lesser public interest in publication. Although there clearly are distinctions between the criminal and coronial jurisdictions, the public reporting of coroner's inquests is very important. The requirement that justice be done in public is equally applicable. We agree with the observations of Sir Mark Potter PFD in *LM (Reporting Restrictions: Coroner's Inquest* [2007 EWHC 1902 (Fam) at [35] - [40] as to the importance of the public interest in inquests.

80. Given all the evidence to which we have referred, and in particular the public interest which arose, it is our view that the balance was strongly in favour of refusing to make the order for anonymity and allowing the press freely to report the inquest, subject to the orders made by the Coroner as set out in paragraph 67 above. The Coroner was plainly right in so concluding.

81. As to the fourth ground, the common law duty of fairness, the analysis under Articles 8 and 10 gives rise to the same result.

Conclusion

82. We therefore dismiss the proceedings on the jurisdiction issue and on the anonymity issue.