A REPORTING RESTRICTION ORDER IS IN FORCE. IT PROHIBITS THE IDENTIFICATION, DIRECTLY OR INDIRECTLY, OF THE MOTHER AND/OR SIBLINGS OF POPPI WORTHINGTON. FAILURE TO COMPLY WITH THE ORDER MAY BE A CONTEMPT OF COURT.

Neutral Citation Number: [2018] EWHC 3386 (Admin)

Case No: CO/1665/2018

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT IN MANCHESTER
DIVISIONAL COURT

Manchester Civil Justice Centre
1 Bridge Street,
Manchester M60 9DJ

Date: 11/12/18

Before :

LORD JUSTICE HICKINBOTTOM

MRS JUSTICE FARBEY
and
THE CHIEF CORONER OF ENGLAND & WALES
HIS HONOUR JUDGE LUCRAFT QC
sitting as a Judge of the High Court

- -

Between :

THE QUEEN ON THE APPLICATION OF
PAUL WORTHINGTON

Appellant

- and -

HM SENIOR CORONER FOR
THE COUNTY OF CUMBRIA

Respondent

- and -

(1) THE MOTHER OF POPPI WORTHINGTON
(2) THE SIBLINGS OF POPPI WORTHINGTON
(3) THE CHIEF CONSTABLE OF CUMBRIA
(4) CUMBRIA COUNTY COUNCIL

Interested Parties

- -
- -

Leslie Thomas QC and **Nick Scott** (instructed by **Farleys Solicitors LLP**) for the **Claimant**
Samantha Leek QC (instructed by **Weightmans LLP**) for the **Defendant**
The Interested Parties neither appearing nor being represented

Hearing date: 3 December 2018
- -

Approved Judgment

Lord Justice Hickinbottom :

Introduction

1. Poppi Worthington died at her home on 12 December 2012. She was 13 months old.

2. The post mortem examination suggested that, shortly before her death, she had suffered acute injuries to her anus and rectum. At the inquest conducted by the Defendant coroner ("the Coroner") in late 2017, a key issue was whether Poppi had been anally penetrated in the hours before her death and, if so, whether that had led to her death. In a lengthy "Review of Evidence, Findings and Conclusion" delivered by the Coroner on 15 January 2018 ("the Review"), the Coroner found that, that night, she had been taken from her own cot to a double bed where she was anally penetrated, but that had not caused or contributed to her death. She had died as a result of her ability to breathe being compromised by an unsafe sleeping environment.

3. The claim now brought by the Claimant, Poppi's father, is narrow. He does not challenge any of those factual findings which, he accepts, the Coroner was entitled to make on the evidence before him. However, he contends that the Coroner erred in referring to the fact of anal penetration in the section of his review which concerned "Conclusion as to Death" and in his "Record of Inquest". He seeks an order requiring the removal of those references.

4. Before us, Leslie Thomas QC and Nick Scott appeared for the Claimant, and Samantha Leek QC for the Coroner. At the outset, we thank them all for their focused and helpful submissions.

5. There is a Reporting Restriction Order in place, made by Peter Jackson J (as he then was) on 11 July 2014, which prohibits the identification of Poppi's mother or siblings, directly or indirectly, by (amongst other things) the publication of their names, current or past addresses or schools, or any picture. We stress that that Order remains in place. It does not prevent the identification of either Poppi or her father.

6. This is the judgment of the court.

The Law

7. The relevant statutory provisions relating to a coroner's duty to investigate deaths are found in Part 1 of the Coroners and Justice Act 2009; and, in this judgment, all statutory references are to that Act unless otherwise appears.

8. Section 1 imposes an obligation on a senior coroner to conduct an investigation into a person's death if he has reason to suspect that the deceased died a violent or unnatural death, or the cause of death is unknown, or the deceased died in state detention.

9. Section 5, under the heading "Matters to be ascertained", provides as follows:

> "(1) The purpose of an investigation under this Part into a person's death is to ascertain—
>
> (a) who the deceased was;

> (b) how, when and where the deceased came by his or her death;
>
> (c) the particulars (if any) required by the [Births and Deaths Registration Act 1953] to be registered concerning the death.
>
> (2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998 (c 42)), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.
>
> (3) Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than—
>
> (a) the questions mentioned in subsection (1)(a) and (b) (read with subsection (2) where applicable);
>
> (b) the particulars mentioned in subsection (1)(c).
>
> This is subject to paragraph 7 of Schedule 5."

10. The three subsections require some explanation. There are two types of inquest. The first type (often called a "Jamieson inquest", as its scope was considered in R (HM Coroner for North Humberside and Scunthorpe) ex parte Jamieson [1995] QB 1) is governed by section 5(1) and (3). By section 5(1), its purpose is to ascertain who the deceased was and "how, when and where the deceased came by his death", as well as certain information required for the registration of the death. Often, as in this case, the focus is upon "how" the deceased came by his or her death; and, under well-established domestic jurisprudence, that has been construed narrowly to mean "by what means" and not "in what broad circumstances" (see, e.g., Jamieson at page 24A per Sir Thomas Bingham MR, and R (Middleton) v West Somerset Coroner [2004] UKHL 10; [2004] 2 AC 182 at [28] per Lord Bingham of Cornhill and the other authorities he there cites). Section 5(3) proscribes a coroner from expressing an opinion on any matter other than those set out in section 5(1), save for a report under paragraph 7 of Schedule 5 concerning the elimination or reduction of the risks of other deaths which plays no part in this claim.

11. The second type (often called a "Middleton inquest", as its scope was considered in Middleton) is an inquest which engages the state's procedural obligation under article 2 of the European Convention on Human Rights ("the ECHR") to conduct a public investigation into a death where its substantive obligations under that article have been (or may have been) violated and it appears that state agents are (or may have been) in some way implicated. In such cases, Middleton (at [35]) held that "how, when and where the deceased came by his death" must be read more broadly as including the purpose of ascertaining, not just by what means, but in what circumstances the deceased came by his or her death. That is now reflected in section 5(2).

12. It is common ground that article 2 is not engaged in this case; and so section 5(2) does not apply. Only section 5(1) and (3) apply.

13. Section 10, under the heading "Determinations and findings to be made", sets out what is to happen at the conclusion of an inquest. So far as relevant to this claim, it provides:

> (1) After hearing the evidence at an inquest into a death, the senior coroner (if there is no jury) or the jury (if there is one) must—
>
> > (a) make a determination as to the questions mentioned in section 5(1)(a) and (b) (read with section 5(2) where applicable), and
> >
> > (b) if particulars are required by the [Births and Deaths Registration Act 1953] to be registered concerning the death, make a finding as to those particulars.
>
> (2) A determination under subsection (1)(a) may not be framed in such a way as to appear to determine any question of—
>
> > (a) criminal liability on the part of a named person, or
> >
> > (b) civil liability."

Therefore, in section 10, "determination" refers to a determination of the matters required to be ascertained under section 5(1)(a) and (b) (including section 5(2), if it applies), and "findings" refers to findings as to the particulars required for registration purposes under section 5(1)(c). In this claim, we are not concerned with findings as to registration particulars, only the determination of matters to be ascertained under section 5(1)(a) and (b), especially how Poppi came by her death.

14. Rule 34 of the Coroners (Inquests) Rules 2013 (SI 2013 No 1616) ("the 2013 Rules"), made under section 45 of the 2009 Act, provides that

> "A coroner or in the case of an inquest heard with a jury, the jury, must make a determination and any findings required under section using Form 2."

"Determination" and "findings" here are used in the same sense as in section 10.

15. Form 2, which accompanies the 2013 Rules, is entitled "Record of an Inquest" and provides for a record to be made in the following form:

> "The following is the record of the inquest (including the statutory determination and, where required, findings) –
>
> 1. Name of the deceased (if known):
>
> 2. Medical cause of death:

> 3. How, when, where, and for investigations where section 5(2) of the [2009 Act] 2009 applies, in what circumstances the deceased came to his or her death: (see note (ii)):
>
> 4. Conclusion of the coroner/jury as to the death: (see notes (i) and (ii)):
>
> 5. Further particulars as required by the Births and Deaths Registration Act 1953 to be registered concerning the death…".

With regard to this form:

i) In respect of the record of the inquest, this form is mandatory.

ii) Paragraphs 1-5 of the form are known as "Box 1", "Box 2" etc.

iii) "Determination" and "findings" are again used in the same sense as in section 10.

iv) Although the coroner may wish to – or be required to – give a reasoned ruling or judgment analysing the evidence and explaining why he has come to the factual findings that he has (see paragraph 35 below), the determination of matters which section 5 requires to be ascertained is to be distilled in Box 3.

v) The "conclusion" referred to in paragraph 4 (i.e. Box 4) was formerly known as the "verdict".

vi) Note (i) provides for various short-form conclusions, including accident and unlawful killing. Note (ii) provides that:

> "As an alternative, or in addition to one of the short-form conclusions listed under Note (i), the coroner or where applicable the jury, may make a brief narrative conclusion".

16. The statutory provisions are supplemented by guidance issued by the Chief Coroner, in the form of "Guidance No 17 – Conclusions: Short-Form and Narrative", issued by the first Chief Coroner (His Honour Judge Peter Thornton) on 30 January 2015 as revised on 14 January 2016 ("the Chief Coroner's Guidance"). This is designed to "assist coroners in the use of short-form and narrative conclusions and with a view to achieving greater consistency across England and Wales" (paragraph 1). The guidance focuses primarily on the matters to be included in Boxes 3 and 4 (paragraph 10), i.e. how, when and where the deceased came by his or her death in Box 3 and the conclusion in Box 4.

17. Paragraph 18 of the Chief Coroner's Guidance states:

> "The coroner (or the jury if there is one) is required, having heard the evidence, and in addition to deciding the medical cause of death (Box 2), to arrive at a conclusion by way of a three stage process.

(1) **To make findings of fact based upon the evidence.**

Where the coroner sits alone the key findings of fact should be stated orally in open court, preferably (during or) after the evidence has been summarised (but not written on the Record of Inquest).

Where there is a jury they need to be directed to make findings of fact for themselves based upon the evidence they have heard. They will not normally record these findings of fact publicly except insofar as they form part of the answer to 'how' or part of a narrative conclusion.

(2) **To distil from the findings of fact 'how' the deceased came by his or her death and to record that briefly in Box 3.**

Normally, the answer to 'how' will be a brief one sentence summary taken from the findings of fact in (1) above.

'How' means 'by what means' (and not 'in what broad circumstances'). This will usually be a description of the mechanism of death.

Examples of 'how' in Box 3 are:

- 'by hanging from an exposed beam using a ligature made from a bedsheet' (with the conclusion of 'suicide' in Box 4).

- 'by drowning while swimming from his small fishing boat in the open sea (with the conclusion of 'misadventure' entered in Box 4)

- 'from injuries caused in a motor collision while a back seat passenger in her father's car' (with a conclusion of 'road traffic collision' entered in Box 4)

- 'from trauma consistent with an un-witnessed fall downstairs' (with the conclusion of 'accident' entered in Box 4

- 'by exposure to asbestos fibres during the course of his occupation as a plumber' (with a conclusion of 'industrial disease' entered in Box 4)

To these words will be added the date and place of death where known and, where necessary, any further words

> which briefly explain how the deceased came by his/her death. (Box 3).
>
> …
>
> Coroners, in their judicial discretion, will use their own form of words. These should be brief, neutral and clear. As under the old law they must not include an opinion other than on the matters which are the subject of statutory determination (section 5(3)…)…
>
> (3) **To record the conclusion, which must flow from and be consistent with (1) and (2) above, in Box 4.**"

18. Paragraph 36 states that:

> "Narrative conclusions are not to be confused with findings of fact in the three stage process. If the three stage process of (1) findings of fact, (2) the answer to 'how', and (3) a short-form conclusion is properly followed, there will often be no need for a narrative conclusion. In general a narrative conclusion should be used only where the three stage process (culminating in a short-form conclusion) is insufficient to 'seek out and record as many of the facts concerning the death as the public interest requires': per Lord Lane CJ in [R v South London Coroner ex parte Thompson (1982) 126 SJ 625)]."

The Procedural Background

19. Poppi's death, and the injuries to which we have referred, have been the subject of extensive investigation by medical experts and consideration in several sets of legal proceedings.

20. First, there were proceedings in the Family Division before Peter Jackson J concerning with the welfare of Poppi's siblings. In a judgment handed down on 28 March 2014 following a fact-finding hearing (now reported as Cumbria County Council v M and F (Fact-Finding No 1) [2014] EWHC 4886 (Fam)), the judge concluded that, in the hours before Poppi's death, the Claimant perpetrated a penetrative anal assault on her, either using his penis or some other unidentified object (see [152]). He found that Poppi later died from a cause which, on the evidence before him, was medically unascertained (see [153]).

21. That judgment was not immediately published. On 11 July 2014, Peter Jackson J made the Reporting Restriction Order to which we have referred (see paragraph 5 above), effectively prohibiting the publication of anything that might, directly or indirectly, identify Poppi's mother or siblings. Then, unusually, in late 2015, there was a further fact-finding hearing before the same judge, involving new evidence as to the proper interpretation of the post mortem. On 19 January 2016, he gave a further judgment (now reported as F v Cumbria County Council [2016] EWHC 14 (Fam)), confirming his earlier findings and directing that appropriately anonymised versions should be published, which they were.

22. In view of the circumstances of the death, an inquest was required. It was held on 21 October 2014, i.e. between the two Family Division hearings and at a time when Peter Jackson J's first judgment remained closed. The coroner was given a copy of that judgment; but he faced the substantial difficulty of conducting a thorough public inquest into Poppi's death consistently with the parallel Family Division proceedings and concomitant restriction on publicly using the first fact-finding judgment. In the event, he heard no evidence. The record of inquest recorded that the cause of death was "unascertained"; and the part of the record headed "How, when and where the deceased came by his or her death" was left blank.

23. In due course, the newly appointed HM Senior Coroner for Cumbria, David Roberts (i.e. the Defendant Coroner) under the authority of the Attorney General sought an order under section 13 of the Coroners Act 1988 to quash the record of inquest and an order that a new investigation be held into Poppi's death. The Coroner submitted that the first inquest was deficient in a variety of ways. Whilst expressing sympathy for the difficulties that met the coroner who conducted the first inquest, on 22 July 2015 this court quashed the record of inquest and ordered a new inquest.

The Inquest

24. The second inquest was conducted between 27 November and 14 December 2017; after which, as we have described, the Coroner took time to consider the evidence and he then delivered the Review on 15 January 2018. This is a very substantial document of nearly a hundred pages, in which the Coroner set out in detail the significant lay and expert evidence (paragraphs 6-117), and his factual findings (paragraphs 118-144) including his findings as to cause of death (paragraph 142-144). In paragraphs 145-151, he set out his "Conclusion as to the Death"; and then, after a short section on "Prevention of Future Deaths (paragraphs 152-154), he set out his Record of Inquest in the required, five-Box form.

25. It is uncontroversial – and expressly accepted by Mr Thomas (see paragraph 7 of his skeleton argument) – that a significant issue at the inquest was whether the Claimant had sexually assaulted Poppi prior to her death and, if so, whether that caused or contributed to her death. The Coroner dealt with the evidence in respect of that issue with patent care, summarising his findings of fact as to what occurred in the house in the early hours of 12 December 2012 in paragraphs 140-141 of the Review. By way of background, Poppi had been unwell that day; and, that night, her mother slept downstairs. Her mother never let her sleep in an adult bed with an adult, because of the inherent risk involved. The Coroner said:

> "140. Looking at all the evidence, I have concluded that the broad sequence of events is probably as follows. At some time after 2.30am Poppi was taken from her cot into the double bedroom and placed in or on the double bed, probably with her dummy and bottle. Her pyjama bottoms and nappy were removed and she was anally penetrated, probably digitally. As a result, Poppi cried out loudly and this probably brought the penetration to an end. The floor boards of the double bedroom were heard by Mother to creak at this time. I find that father brought Poppi's pink elephant pillow into his bedroom at some point and it may be that it was at this time, but it is not possible

> to ascertain from the evidence. In any event, Poppi was placed back into her nappy, but not her pyjama bottoms, and the poppers on her vest were not re-fastened. The penetration caused bruising to the anus and parametrium and tears to the rectal canal. Poppi bled from the tears, and possibly the irritated mucosal layer, causing a quantity of blood to build up in her rectal canal.
>
> 141. I find that after the penetration the bedclothes were placed over Poppi and, given that no further noise was heard from her by Mother, that she went to sleep. I find that Poppi and her father both went to sleep beside each other for some significant period of time, with Poppi in such a position that her breathing was compromised, either due to the position of the bedclothes, her position within the bed or overlaying, or a combination of all three. Her viral infection would in all probability, also have compromised her ability to breathe freely. At some point she defecated but I am not able to ascertain precisely when. Nor am I able to ascertain precisely when father went downstairs saying that he was collecting a nappy, but I find that he did so at some point. In any event, when father awoke he discovered Poppi was no longer breathing and, shortly before 5.56am, he took he downstairs in an unresponsive state. I find that, in fact, she was dead at that point."

26. In paragraphs 142-144, the Coroner reached conclusions as to the cause of death. He found that Poppi had lived for some time after the penetration, and he consequently concluded that it was not a cause of death. Rather, he concluded that she had died from asphyxia resulting from obstruction of her airways whilst she was asleep.

27. As we have indicated, the Claimant does not challenge any of those findings of fact. However, he objects to certain passages from the section of the Review headed "Conclusion as to the Death" and the Record of the Inquest.

28. In the section "Conclusion as to Death", the Coroner set out his response to the submissions as to the possible conclusions (i.e. verdicts) open to him, which included a short-form conclusion of unlawful killing (i.e. death caused by an unlawful act of penetration) or accidental death. He did so as follows (italics added, as identifying those passages to which the Claimant objects, i.e. those referring to anal penetration):

> "147. … I first considered whether a short-form Unlawful Killing conclusion is available to me and ought to be recorded. In order to reach this conclusion I would need to be satisfied, beyond reasonable doubt, that Poppi had died as a result of an act of murder or manslaughter. It is entirely clear that this conclusion is not available to me, whether on the basis of unlawful act manslaughter or otherwise. *Although I have found, on the balance of probabilities, that Poppi was anally penetrated prior to her death, I have also found that she did not die in the course of or immediately following the penetration*

> *and the penetration did not cause her death.* There can, *therefore,* be no question of an Unlawful Killing conclusion. *In the circumstances, it is not necessary for me to consider whether I am satisfied beyond reasonable doubt that the penetration took place and I make no express finding as to that. As stated above, I have come to a conclusion on that issue on the basis of the lower standard of proof.*
>
> 148. I next considered whether a short-form Accidental Death conclusion is available to me and should be recorded. This is an appropriate conclusion where a coroner is satisfied, on the balance of probabilities, that the death has resulted from an unintended act or omission or is the unintended consequence of a deliberate act or omission. On the basis of my findings of fact this conclusion may be open to me but, in my judgment, it would not be appropriate to record it. Given that Poppi had been *harmed and* placed in an unsafe sleeping environment prior to her death, I do not consider that this short-form conclusion properly reflects my conclusion as to death."

29. As his Record of Inquest, the Coroner stated as follows (italics again identifying the words to which the Claimant objects, i.e. again the reference to anal penetration):

> "Box 1: Poppi Iris Worthington.
>
> Box 2: Asphyxia
>
> Box 3: On the 12th December 2012 the Deceased was at her home address when, at some time after 2.30am, she was taken from her cot to a double bed *where she was anally penetrated*. She subsequently went to sleep in the double bed with an adult sleeping close to her. She was suffering from an upper respiratory tract infection and her ability to breathe was compromised by her unsafe sleeping environment. Shortly before 05.56 hours she was found to have stopped breathing. Resuscitation was commenced at her home and was continued by the emergency services at the [hospital] to where she was taken, but she was asystolic throughout. Despite resuscitation her death was pronounced at 07.07 hours at the [hospital].
>
> Box 4: Narrative Conclusion: The Deceased died as a result of her ability to breathe being compromised by an unsafe sleeping environment".

In Box 5, the Coroner set out his findings in relation to registration particulars.

The Claim

30. As we have indicated, the Claimant through Mr Thomas challenges neither the scope of the Coroner's inquiry nor any of the Coroner's findings of fact. He specifically accepts that the Coroner was required to make findings of fact as to whether a

penetrative assault occurred and, if so, whether it caused Poppi's death (in which case he would have been obliged to have come to a conclusion of unlawful killing) (paragraph 18 of his skeleton argument).

31. However, Mr Thomas submits that, in the section of his Review "Conclusion as to the Death" and the Record of the Inquest, the Coroner did not confine himself to ascertaining and recording "how" Poppi's death occurred as required and limited by section 5(1) and (3), but rather trespassed into the circumstances in which it occurred, essentially treating this as an article 2 case to which section 5(2) applied. The Coroner had found, clearly and expressly, that anal penetration had *not* caused or contributed to Poppi's death; and thus, he submits, the factual finding of such penetration could not be relevant to "how" she died, which (as the Coroner found) was asphyxia as a result of her ability to breathe being compromised by an unsafe sleeping environment. The references to anal penetration in paragraphs 147 and 148 of the Review, and in the Record of the Inquest, were therefore inappropriate and unlawful as they were proscribed by section 10. Mr Thomas submits that the Coroner's error is reflected in paragraph 5.2(iii) of the Response to the Claimant's Statement of Facts and Grounds, where the Coroner says that anal penetration "was an integral part of the factual matrix which formed the immediate circumstances of her death". By including the references he did – as identified by italics in the quotations in paragraphs 24 and 25 above – the Coroner contravened section 5(3) read with section 5(1), and section 10.

32. By way of relief, the Claimant does not seek an order quashing the record of inquest, but only the strike out of the relevant references. Although this would leave intact the published findings of fact which these references merely reflect, Mr Thomas submitted that the Claimant should be entitled to that relief if the inclusion of the references is found to be unlawful because the part of the Review which amounts to the determination (which, he submits, includes paragraphs 147-148 and the Record of the Inquest) will be the only part that is formally retained and, in the future, it is the only part to which reference will in practice be made. The relief sought therefore has some real practical significance for the Claimant.

Discussion

33. Despite Mr Thomas' eloquence, we are unpersuaded by his submissions, for the following reasons.

34. Mr Thomas sought to distinguish between the Coroner's findings of fact (which he does not seek to challenge) and his "determination" of the matters to be ascertained under section 5(1), notably "how" Poppi came by her death. Paragraphs 147 and 148, as well as Box 3, he submitted, fell within the "determination" part of the Review. Miss Leek doubted the validity of such a distinction in those terms, as do we.

35. Paragraph 18 of the Chief Coroner's Guidance (quoted at paragraph 17 above) recognises a three-stage process in respect of an inquest, namely (i) making findings of fact on the evidence, (ii) distilling from those findings of fact "how" the deceased came by his or her death and to record that briefly in Box 3, and finally (iii) recording in Box 4 the conclusion (i.e. verdict), which must flow from and be consistent with (i) and (ii). This reflects the fact that coroners are entitled, and in some cases obliged, to analyse the evidence and give rulings or judgments as to why they have reached a

particular findings of fact and conclusions or (if there is a jury) why they are leaving particular findings or conclusions to the jury (see R (Farah) v HM Coroner for the Southampton and New Forest District of Hampshire [2009] EWHC 1605 (Admin) at [20(e)] per Silber J).

36. The Coroner clearly adopted this process, setting out his analysis and findings of fact in the body of the Review, before setting out in Boxes 3 and 4 of his Record of the Inquest both "how" Poppi came by her death and the conclusion. Although paragraphs 147-148 (about which Mr Thomas complains) deal with the Coroner's reasoning as to why a short-form conclusion as to either unlawful killing or accidental death was not appropriate, his determination of the question "how" as mentioned in section 5(1)(a) is set out in Box 3. In the light of the concession that the findings of fact were unimpeachable, the criticism of those two paragraphs is unfounded.

37. Of course, insofar as the Claimant is concerned about the part of the Review to which, in the future, formal reference will be made, that will be the Record of the Inquest. What goes before is the analysis of the evidence and findings of fact to which Box 3 of the Record of the Inquest is a distillation of "how" Poppi came by her death. Therefore, in our view, the proper focus of the complaint is upon the words "… where she was anally penetrated…" in Box 3.

38. But, in any event, we do not consider that the Coroner erred in recording his finding of anal penetration in his determination, whether viewed as restricted to Box 3, or as extending to paragraphs 147-148.

39. None of the references compromises section 5(3), because none expresses an opinion: the references merely repeat a finding of fact made earlier in the Review.

40. However, nor in our view do they breach section 10(1) by, in making a determination of one of the questions mentioned in section 5(1)(a) and (b) (namely the "how" question), straying beyond the means by which Poppi came by her death, into the wider circumstances attending her death.

41. It is common ground and uncontroversial that the scope of enquiry is a matter of judgment for the coroner, to which, quite lawfully, coroners might respond differently subject to challenge on only the usual public law grounds (see, e.g., McDonnell v HM Assistant Coroner for West London [2016] EWHC 3078 (Admin); [2016] 154 BMLR 188 at [28] per Beatson LJ). Whilst of course it is subject to the statutory restrictions in section 5(1) and (3), what goes into the determination in respect of how someone came by his or her death equally requires an exercise of judgment by the coroner.

42. We do not regard the observation of Lord Brown of Eaton-under-Heywood in R (Hurst) v London Northern District Coroner [2007] UKHL 13; [2007] 2 AC 189 at [51], upon which Mr Thomas relied, to suggest otherwise. Lord Brown said:

> "Of course, the scope of the inquiry is ultimately a matter for the coroner. The 'verdict' and findings, however, are not. The Jamieson construction of 'how' severely circumscribes these. But where the Middleton construction applies, the verdict and findings are not merely permitted, but *required* to be wider…" (emphasis in the original).

Lord Brown was there merely emphasising that, where article 2 of the ECHR is engaged, the scope of purpose of an inquiry is wider than if it is not. He clearly does not intend to suggest that no exercise of judgment is required by a coroner in identifying the findings of fact that are deemed necessary for the determination of the matters mentioned in section 5(1) (including "how"), or the matters that should be recorded within the determination of such matters.

43. It is 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 these facts any determination of blame (see paragraph 36 of the Chief Coroner's Guidance quoted at paragraph 18 above; and paragraph 16.40 of the Brodrick Committee Report on Death Certification and Coroners (1971) (Cmnd 4810), taken up by Lord Lane LCJ in Thompson (see paragraph 18 above) and by Baroness Hale in Hurst at [21]). In these circumstances, where one of the main issues in an inquest is whether death was caused by reflex cardiac arrest as a result of trauma, it seems to us that the Coroner was at least entitled to include in the Record of Inquest why he found that not to be the case, leaving another cause (here, asphyxia) as the main, if not only, suggested cause.

44. However, Mr Thomas maintained that, once the Coroner had concluded at the findings of fact stage that anal penetration was not causative of death, that penetration passed beyond the means of death into the mere wider circumstances surrounding the death; and the Coroner therefore could not lawfully include it in his determination of the "how" question. In the determination of a section 5(1) question, the coroner could not refer to anything he had concluded was not a cause of death.

45. However, the Coroner particularly considered that point. In his response to paragraph 5.2(iii) of the Claimant's letter before claim dated 21 March 2018, he said:

> "As for the Record of Inquest itself, I do not agree that the finding of anal penetration should have been omitted from Box 3. I agree that article 2 of the ECHR was not engaged in this inquest (there was no basis for suspecting that Poppi's death was caused or more than minimally contributed to by any state agency of her right to life). Therefore, it would not have been appropriate for me to make or record findings as to any 'wider' circumstances surrounding her death. I do not agree, however, that my finding that Poppi was anally penetrated shortly before her death should be characterised in this way. Rather, it was an integral part of the factual matrix which formed the immediate circumstances of her death. The anal penetration was the direct cause of the injuries sustained by Poppi shortly before her death and was also the immediate circumstance which resulted in Poppi being in an unsafe sleeping environment."

Consequently, the Coroner did not consider that it offended either section 5(3) or 10(1) of the 2009 Act; or section 10(2) because the reference to anal penetration was factual and the person responsible for the penetration (even if apparent from the evidence before the inquest) was not named.

46. In our view, neither the Coroner's approach nor his conclusion can be faulted. To set out a negative conclusion in the determination of a section 5(1) matter (e.g. that something suggested as causative did not cause the death) is not proscribed by the statutory provisions; and, in the circumstances of a particular case, it may be appropriate or even obligatory to ensure the legal requirements for a such a determination are met. As Mr Thomas submitted, each case is fact-sensitive. The Coroner in this case was entitled – and, in our respectful view, right – to conclude that it was appropriate to include in Box 3 of the Record of the Inquest references to the anal penetration in the hours before Poppi's death because it was essential to explain why Poppi was in the unsafe sleeping environment which caused her death. It was also clearly necessary for the Coroner to explain in his Review why he had concluded that this was not unlawful killing, as he did in paragraph 147 (i.e. he was satisfied that there had been anal penetration but not that this was causative of death); and why he had concluded that this was not accidental death, as he did in paragraph 148 (i.e. she had been harmed and then placed in an unsafe sleeping environment). In coming to those reasoned conclusions, the Coroner used patently careful and appropriately neutral language that did not offend either sections 5 or 10 or the Chief Coroner's Guidance.

47. In pressing for the relief he seeks – striking out of the references to anal penetration in the determination part of the review – Mr Thomas submitted that it would be of real practical benefit to the Claimant because, in the fullness of time, it would be only the Record of the Inquest that would be retained and formally referred to. We doubt the factual premise upon which that submission is based, namely that the main analysis and factual findings of the Coroner in paragraphs 1-144 (or even, as we consider them to be, paragraphs 1-154) will be lost, forgotten or dissociated from the Record itself. But, if that premise were ever to be made good, then the Record would clearly be deficient without reference to the finding of anal penetration. It would fail adequately to explain why Poppi was in the unsafe sleeping environment which caused her death. Certainly, in our view, the Coroner was entitled to include that reference in Box 3 as well as in paragraphs 147 and 148.

48. Counsel were agreed that there is no authority directly on the point as to the scope of a coroner's obligation to record a determination of one of the section 5(1) matters. We did not find the authorities to which we were referred of any great assistance; although we found none inconsistent with the interpretation of the statutory scheme we favour, and some at least consistent with it. The following are worthy of mention.

49. Whilst of course we accept that the scope of purpose of a Middleton inquest is wider than that of a Jamieson inquest – and we know that Lord Brown in Hurst referred to the "severe" circumscription of the verdict and findings in the latter (see paragraph 42 above) – we reject the suggestion that the scope even in a Jamieson inquest is especially narrow. The question of how the deceased came by his death is clearly wider than merely finding the medical cause of death – a coroner is required to "enquire into acts and omissions which are directly responsible for the death" (R v HM Coroner for the Western District of East Sussex ex parte Homberg, Roberts and Manners (1994) 158 JP 357) – which is now reflected in Form 2, which has separate Boxes for medical cause of death and "how" the death came about. As Baroness Hale observed in Hurst at [21], the court in Jamieson did not disapprove previous statements such as that of Croom-Johnson LJ in R v Southwark Coroner ex parte

Hicks [1987] 1 WLR 1624 at page 1634 that "the word 'how' is wide…"; nor the words of Lord Lane LCJ in Thompson cited at paragraph 18 above to the effect that the function of an inquest is to seek out and record as many of the facts concerning a death as the public interest requires. We are unconvinced by Mr Thomas's submission that it is sufficient to record such findings in a ruling; and that a coroner is, in the circumstances of this case, positively prohibited from including them in the determination of the "how" question.

50. McDonnell (cited at paragraph 41 above) concerned a deceased who had died as a result of fatal heart arrhythmia triggered by a vaso-vagal event in the presence of excessive codeine and various other drugs. The deceased had been advised on numerous occasions that, with the drug load he was maintaining, he should have an ECG. The conclusion of the inquest recorded that he had been advised to have an ECG, but he had not taken up that advice. We appreciate that that was an application to quash a record of inquest on the basis that the enquiry and recording did not go far enough; but Beatson LJ clearly considered the recording of the ECG advice was unexceptional, and that the conclusion "factually and accurately summarises the advice that was given but not taken up by the deceased" (see [43]). We accept that this is of limited force for the purposes of this claim; but it does show that the court will be slow to intervene to criticise an accurate, neutral and otherwise inoffensive recital of facts which a corner considers to be relevant to "how" the death occurred even in a Jamieson inquest.

51. In our view, although bound to remain within the scope of section 10, it would be wrong as a matter of principle for this court to attempt to micromanage inquests by constraining the proper discretion of a Coroner to record the answer to the "how" question in light of all his findings of fact. A court should be cautious before interfering to require the striking out of unchallengeable findings of fact which a coroner has carefully considered to be sufficiently important by way of explanation of the means of death to include them within a determination of a section 5(1) question including how an individual came by his or her death.

52. In this case, the Coroner's Review was exemplary. He considered and analysed the evidence with particular care, making findings of fact which, as Mr Thomas accepts, are unchallengeable. In our view, he did not err in law in including the references to the anal penetration, either in Box 3 of the Record of the Inquest, or in paragraphs 147-148 of the narrative.

Conclusion

53. For those reasons, we dismiss this claim.

Costs

54. The Coroner seeks an order that the Claimant pays his costs of the claim.

55. The general rule is that an unsuccessful party pays the successful party's costs (CPR rule 44.2(2)(a)); but, in appropriate circumstances, the court may make a different order (CPR rule 44.2(2)(b)). In this case, the Coroner was successful in defending the claim. However, Mr Thomas submits that there are good grounds from departing from the usual order that.

56. In paragraph 2 of her skeleton argument, Miss Leek said that her submissions and attendance at the hearing were intended to assist the court only, and the Coroner took an entirely neutral stance. She there referred to R (Davies) v HM Deputy Coroner for Birmingham [2004] EWCA Civ 207 consequently applying. Mr Thomas relies upon that acceptance.

57. In Davies, the Vice President of the Court of Appeal (Civil Division) Brooke LJ summarised the costs position of coroners and other judicial bodies in judicial reviews of their decisions at [46] as follows:

> "(i) The established practice of the courts was to make no order for costs against an inferior court or tribunal which did not appear before it except when there was a flagrant instance of improper behaviour or when the inferior court or tribunal unreasonably declined or neglected to sign a consent order disposing of the proceedings.
>
> (ii) The established practice of the courts was to treat an inferior court or tribunal which resisted an application actively by way of argument in such a way that it made itself an active party to the litigation, as if it was such a party, so that in the normal course of things costs would follow the event.
>
> (iii) If, however, an inferior court or tribunal appeared in the proceedings in order to assist the court neutrally on questions of jurisdiction, procedure, specialist case-law and such like, the established practice of the courts was to treat it as a neutral party, so that it would not make an order for costs in its favour or an order for costs against it whatever the outcome of the application.
>
> (iv) There are, however, a number of important considerations which might tend to make the courts exercise their discretion in a different way today in cases in category (iii) above, so that a successful applicant..., who has to finance his own litigation without external funding, may be fairly compensated out of a source of public funds and not be put to irrecoverable expense in asserting his rights after a coroner (or other inferior tribunal) has gone wrong in law, and there is no other very obvious candidate available to pay his costs."

58. In further explanation of (iii), Brooke LJ continued at [48]:

> "Needless to say, if a coroner, in the light of this judgment, contents himself with signing a witness statement in which he sets out all the relevant facts surrounding the inquest and responds factually to any specific points made by the claimant in an attitude of strict neutrality, he will not be at risk of an adverse order for costs except in the circumstances set out in paragraph 47(i) above...".

59. In the case before us, the Coroner did indeed state that he proposed taking a neutral position in the claim. However, he did not do so in practice. In the written submissions in paragraphs 27 and following of Miss Leek's skeleton argument, and in the oral submissions she made, Miss Leek sought to persuade us that the Review should not be redacted as the Claimant sought it to be. In those circumstances, had the Claimant's claim been successful then, everything else being equal, he would have been entitled to his costs against the Coroner. As the Coroner succeeded, he is entitled to the usual costs order against the Claimant. There is no suggestion that the Claimant's case was prepared and presented in any different way as the result of the Coroner's assertion that he proposed to maintain a neutral stance: both parties clearly sought to persuade us, to the best of their considerable ability, that their submissions should be preferred. An order that the Claimant pays the costs of the Coroner is therefore not in any way unjust or unfair to the Claimant.

60. For those reasons, we shall order the Claimant to pay the Coroner's costs of the claim, subject to the usual proviso in a legally aided case that there shall be no enforcement of the Claimant's liability to pay costs save following and in accordance with an assessment of the Claimant's means pursuant to section 26(1) of the Legal Aid, Sentencing and Punishment of Offenders Act 2012.

61. However, we should add that we do not condone any practice of Coroners or any other form of tribunal defendant in judicial review proceedings, insofar as it exists, of stating that they are taking a neutral stance in respect of those proceedings, but then making submissions that are clearly not neutral but partisan. The tribunal must decide what course it proposes to take, neutral or not neutral, and then make submissions accordingly. If it decides on neutrality, it must not make any submissions that are less than neutral. In particular, it cannot seek to avoid the adverse consequences of being less than neutral by mere reference to Davies; and, if it seeks to do so and is unsuccessful in defending the claim, then it will run the risk of having a costs order against it in line with usual cost principles and CPR rule 44.2(2)(a).