CO/1691/2015

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

Royal Courts of Justice
Strand
London WC2A 2LL

Wednesday, 22 July 2015

B e f o r e:

LORD JUSTICE BURNETT

MR JUSTICE HOLROYDE

Between:
HER MAJESTY'S SENIOR CORONER FOR THE COUNTY OF CUMBRIA
Claimant

v

IAN SMITH, **HER MAJESTY'S FORMER SENIOR CORONER FOR SOUTH AND EAST CUMBRIA**
Defendant

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(Official Shorthand Writers to the Court)

Miss Alison Hewitt (instructed by Messrs Weightmans) appeared on behalf of the **Claimant**
The Defendant did not appear and was not represented

J U D G M E N T
(Approved)

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1. LORD JUSTICE BURNETT: On 12 December 2012, Poppi Iris Worthington was certified dead at Furness General Hospital. An ambulance had been called to her home just before 6 O'clock in the morning at the instigation of her parents. Poppi was 13 months old.

2. The post mortem examination conducted on behalf of the coroner suggested that some time before her death, perhaps weeks, Poppi had sustained fractures to her right lower leg and that shortly before her death she suffered acute injuries in the region of her anus. Her injuries and their causes were examined by a raft of medical experts, who in due course gave evidence before Jackson J in High Court Family Division proceedings which were concerned with the welfare and future of Poppi's siblings. There was a fact-finding hearing in the course of which the judge made findings relating to the cause of the injuries. The judge concluded that the cause of death itself was unascertained.

3. His judgment, given on 28 March 2014, is currently subject to embargo and thus is not in the public domain. One of the reasons for that embargo has been to avoid any possibility of prejudicing criminal proceedings. There are orders in place in the Family Court to protect from publication the identity of Poppi's siblings and mother, but not her father. The order relating to the judgment prohibits its publication *pro tem*, but the judge envisages that at some stage his fact-finding conclusions will be made available. The order relating to the children and their mother is a prohibition against publication of material specifically set out in that order, or tending to lead to the identification of the children or their mother.

4. The circumstances of the death are such that an inquest had to be held. However, the coroner faced difficulties in reconciling his duty to conduct a thorough public inquest into the death of this child with the parallel Family Court proceedings and the concomitant restriction on using the judgment publicly at an inquest. There was also a continuing police investigation.

5. An inquest was held on 21 October 2014. No evidence was called. The coroner indicated that he had taken account of and adopted the factual findings made by the judge. He had been provided with a copy of the judgment, but was unable to refer to those findings. So it was that no evidence was put into the public domain concerning the circumstances in which Poppi died. The record of the inquest noted that the cause of death was “unascertained” and that she had died at the hospital. It states the names and addresses of both parents and for that reason its content cannot be published because of the Family Court order. The part of the record which is headed "How, when and where the deceased came by his or her death" has been left blank.

6. This is an application to quash the inquisition and for an order for a new inquest. The application is made by the newly appointed Senior Coroner for Cumbria under the authority of the Solicitor General acting for the Attorney General, pursuant to section 13 of the Coroners Act 1988, as amended by the Coroners and Justice Act 2009 (Consequential Provisions) Order 2013. That provides:

7.

"(1)This section applies where, on an application by or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner ('the coroner concerned') either—

(a) that he refuses or neglects to hold an inquest [or an investigation] which ought to be held; or

(b) where an inquest [or an investigation] has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is necessary or desirable in the interests of justice that [an investigation (or as the case may be, another investigation)] should be held.

(2) The High Court may—

(a) order an [investigation under Part 1 of the Coroners and Justice Act 2009] to be held into the death either-

(i) by the coroner concerned; or

(ii)by [a senior coroner, area coroner or assistant coroner in the same coroner area];

(b) ...

(c) where an inquest has been held, quash [any inquisition on, or determination or finding made at] that inquest."

8. The Senior Coroner for Cumbria in post at the end of 2014, who conducted the inquest, has since retired. He takes a neutral stance in these proceedings and does not oppose the application. He has provided the court with a helpful summary of his approach in this unusual and difficult case. It is clear that he proceeded with a view to balancing his obligations under the Coroners Act 2009 with the reality that he could not refer to the content of the Family Court judgment because of the embargo. It is clear from his statement that he was particularly mindful that much time had passed since the sad death of Poppi.

9. Miss Hewitt, who appears for the new coroner this morning to pursue the application, has indicated that the legal representatives of all those involved in the inquest indicated at the pre-inquest review that they agreed with the coroner's approach, save for the representative of the Chief Constable who would have preferred the matter to be adjourned. I should note that the chief constable supports this application.

10. The coroner hearing the inquest had regard to guidance issued by the Chief Coroner on cases in which the Family Court has made factual findings regarding the death of a child.

11. For reasons which I will briefly explain, in my judgment this is a clear case in which a fresh inquest should be held. However, I would record my sympathy for the coroner in trying to contend with the very difficult position in which he found himself.

12. A coroner is required by section 1 of the 2009 Act to investigate deaths where he has reason to suspect that the deceased died a violent or unnatural death, that the cause of death is unknown or that the deceased died in custody. Sections 5 and 10 of the 2009 Act, as material, provide:

> "**5 Matters to be ascertained**
>
> (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 1953 Act 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 Determinations and findings to be made**
>
> (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 1953 Act to be registered concerning the death, make a finding as to those particulars."

13. Miss Hewitt submits that the inquest conducted last October was deficient for four reasons, which are, to some extent, linked. First, the findings of the Family Court, which the earlier coroner said he had adopted, were not made public or recorded on the form. She submits that the statutory duty imposed upon the coroner was thus not fulfilled. Miss Hewitt further submits that the difficulties could have been avoided had the coroner adjourned the inquest until a time after the embargo on the judgment was lifted.

14. Secondly, it is now clear that the Family Court proceedings are to be reopened for a further fact-finding hearing. That is a relatively unusual procedure, but it has been considered necessary by the judge in this case because of the availability of further expert evidence. We are told that that hearing is currently listed to take place in November this year.

15. Thirdly, there is at least a possibility, submits Miss Hewitt, that the open conclusion reached by the coroner might be different following further investigation by the Family Court and a new inquest. Fourthly, there has been a parallel investigation by the Local Safeguarding Children's Board. That is being conducted with a view to determining whether there were any failings on the part of state agencies. Its review is awaited. That may spawn a necessary investigation by the coroner into possible state failings for the purpose of Article 2 of the ECHR.

16. Miss Hewitt has also explained in the course of her submissions this morning that a report from the Independent Police Complaints Commission has recently been received. I should emphasise that that report is not concerned with any dealings between the family concerned and the police before Poppi's death. It is concerned with the quality of the investigation into her death which followed.

17. The obligations of a coroner under section 5 of the 2009 Act are the modern embodiment of legislation stretching back, in very similar terms, to the Coroners Act 1887 and long before that in both statute and at common law. For the purpose of recording the required facts and conclusions a coroner must of course act on evidence. A hearing must be in public, save in the limited circumstances sanctioned by the statutory scheme which have no application in this case, namely in the interests of national security (see Coroners (Inquests) Rules 2012, rule 11(3)). The effect of the procedure followed by the coroner in this case was, in my judgment, to take all the evidence in private. It should not be forgotten that the death of Poppi was investigated and required a coronial investigation because there is reason to suspect that her death was violent or unnatural and because of the uncertainty over the cause of death. It hardly needs stating that the public investigation of such deaths is of great importance.

18. In the language of section 13, it follows that the inquest which was conducted last October was irregular because it failed to perform this central function. Furthermore, it did not result in the recording of the facts which are required by the statutory scheme

and, as I have indicated, evidence was taken in private in circumstances which were not permitted. This conclusion is sufficient for the application to succeed. In those circumstances it is unnecessary to consider Miss Hewitt's ancillary submissions.

19. So far as the future conduct of the inquest is concerned, there are a number of observations that I would make. Whilst there is a clear statutory framework which governs the relationship between coronial investigations and criminal proceedings, there is nothing similar relating to family proceedings. In cases involving the death of a child it is not uncommon for there to be criminal proceedings, or at least consideration whether there should be such proceedings, alongside Family Court proceedings relating to any other children concerned. The Chief Coroner issued the guidance to which I have referred. It is Guidance No 13 entitled "FAMILY COURT PROCEEDINGS - FINDINGS OF FACT ADMISSIBILITY IN THE CORONER'S COURT". The guidance was issued on 10 April 2014. It expresses the Chief Coroner's carefully researched view about the circumstances in which a coroner might introduce the factual conclusions of a judge as evidence in an inquest. The President of the Family Division approved the guidance. It is designed to avoid the need to hear all the same evidence more than once, save for good reason.

20. The chief coroner explained in his guidance that the law on the question had not been decided and that coroners would have to determine how to proceed in the light of the circumstances of an individual case and submissions advanced by interested persons. We have heard no submissions on whether the guidance represents the law and so it would not be appropriate in this case to express a view about it. Nonetheless, it seems to me apparent that all lawful steps should be taken to avoid unnecessary duplication of effort.

21. The Senior Coroner for Cumbria will now be charged with carrying out the coronial investigation and in due course holding a fresh inquest. It will be for him to determine its scope, having considered submissions from interested persons. I have noted that the judge will be conducting the next fact-finding hearing in November. Plainly, the new inquest cannot take place before then, as Miss Hewitt recognised on behalf of the applicant coroner. There may yet be developments not only in relation to the family proceedings, but also in connection with any criminal investigation being conducted by the police. As the guidance itself notes between paragraphs 12 and 14, if it is concluded that the findings of the judge should be admitted in the way suggested, there will need to be close co-operation between the two courts to ensure that any embargo has been lifted and necessary redactions made to the judgment.

22. The material placed before this court suggests that there may be some misunderstanding of the reach of the reporting restriction order made by the judge in the Family Court. That is now set out in a revised order dated 4 January 2015. It concerns restrictions on publishing information. It does not inhibit what may be said in the course of inquest proceedings, subject of course to the lifting of the embargo, nor in any way seek to constrain the coroner in the discharge of his statutory duties.

23. I would quash the record of inquest into the death of Poppi Iris Worthington of 21 October 2014 and order that an investigation under Part 1 of the Coroners and Justice Act 2009 be held into her death by the coroner concerned.

24. MR JUSTICE HOLROYDE: I agree with all that my Lord has said as to the determination of this claim and the reasons therefore. I also agree with my Lord's observations as to the fresh inquest which must now be held. I would wish to echo my Lord's expression of sympathy for the difficulties which confronted the former senior coroner in October 2014.

25. LORD JUSTICE BURNETT: Thank you, Miss Hewitt. Thank you for the order. We will make the order in the terms that you have handed in, which I hope I reflected accurately in what I said towards the end of my judgment.

26. MISS HEWITT: Sorry to bob up as you began your judgment. The reason I did, and it may be excessive caution, was that in referring to two injuries, one earlier and one more close to death, I was a bit fearful that that may encroach on the prohibition of the facts and those matters are not apparent from anything other than the judgment.

27. LORD JUSTICE BURNETT: No, but that information comes from evidence which the coroner himself obtained. In other words, post-mortem examinations. For that reason I myself thought that we were on safe territory.

28. MISS HEWITT: I am grateful for that indication.

29. LORD JUSTICE BURNETT: Thank you very much indeed.