Hilary Term
[2025] UKSC 15
On appeal from: [2023] EWCA Civ 331

JUDGMENT

Abbasi and another (Respondents) *v* Newcastle upon Tyne Hospitals NHS Foundation Trust (Appellant); Haastrup (Respondent) *v* King's College Hospital NHS Foundation Trust (Appellant)

before

Lord Reed, President
Lord Hodge, Deputy President
Lord Briggs
Lord Sales
Lord Stephens

JUDGMENT GIVEN ON
16 April 2025

Heard on 15 and 16 April 2024

Appellants
Gavin Millar KC
Fiona Paterson KC
(Instructed by Sintons LLP (Newcastle upon Tyne) and Hill Dickinson LLP (London City))

Respondents
Bruno Quintavalle
(Instructed by Andrew Storch Solicitors (Reading))

1st Intervener (British Medical Association)
Jenni Richards KC
(Instructed by TLT LLP (Bristol))

2nd Intervener (Royal College of Nursing)
Fenella Morris KC
(Instructed by Bates Wells & Braithwaite LLP (London))

3rd Intervener (Faculty of Intensive Care Medicine)
Alex Ruck Keene KC (Hon)
(Instructed by Bevan Brittan LLP (Bristol))

4th and 5th Interveners (Royal College of Paediatrics and Child Health and Paediatric Critical Care Society)
Nicola Greaney KC
Ian P Brownhill
(Instructed by DAC Beachcroft LLP (London))

6th Intervener (Free Speech Union)
Tom Cross KC
Raphael Hogarth
(Instructed by Branch Austin McCormick LLP (London))

LORD REED AND LORD BRIGGS (with whom Lord Hodge and Lord Stephens agree):

1. Introduction

1. The High Court is occasionally called upon to decide whether life-sustaining treatment being given in hospitals to gravely ill children should be continued or withdrawn. The proceedings are often urgent, and frequently come to an end when the child dies, either because the court grants a declaration that it is in the child's best interests that life-sustaining treatment should be withdrawn, or because the child dies naturally despite having received life-sustaining treatment before the court's decision can be made. The question is always: what is in the child's best interests? There is sometimes disagreement, typically between parents and clinicians, but sometimes between clinicians themselves, as to whether life support should continue to be provided. Those disagreements can become emotionally charged.

2. Although the proceedings in court are designed to resolve such disagreements, the effect of their commencement and of any public hearing is typically to expand the dispute into the public domain, because of reporting by the press, radio and television and through dissemination on social media. At that point the experience of recent cases is that a disagreement about the child's best interests can turn into an uncontrolled furore in the public arena, in which some of the protagonists resort to abuse directed at members of the clinical team treating the child, for example in the form of vilification on social media, or by shouting abuse at staff outside the hospital concerned. This can amount to harassment of the staff affected, leading to distress, disillusionment, psychological illness, demotivation and even withdrawal from that vital work. It can also have an adverse effect upon the quality of the treatment being given to the sick child.

3. The judges of the Family Division, to whom these decisions are assigned, have developed a practice of seeking to limit this risk by issuing injunctions at the outset of the proceedings which prohibit anyone from revealing the identity of the clinical team and the hospital where the child is being treated, and sometimes also the identity of the child, their family, the relevant NHS trust, and other individuals with an involvement in the child's treatment and care. Typically the parents themselves are among those bound by the injunction. Such injunctions have been described as reporting restriction orders, but unlike reporting restriction orders as ordinarily understood, the effect of the injunctions is not solely or primarily (if at all) to restrict the reporting of information which has emerged in open court. Their effect is to prevent the identification of persons and institutions involved in the treatment and care of the child in question, whether or not those persons and institutions have been mentioned in court, and whether or not the court proceedings were held in public.

4. The issues which have led to this appeal are not principally concerned with the original granting of the injunctions, which in the two cases heard together on this appeal was effectively unopposed. Nor are they concerned with the effect of the injunctions while the proceedings remain active. Rather they arise from the continuation of the injunctions after the proceedings have concluded. Under the current practice in the Family Division, at least as exemplified by the cases under appeal, an injunction of indefinite duration is granted at the outset of the proceedings, so that it continues to inhibit disclosure until someone successfully applies for its variation or discharge.

5. In the two cases under appeal the parents of the children concerned applied, after the children had died, to be released from the restrictions imposed by the relevant injunction. They wished to tell their story about what had happened to them and their child, both in hospital and in court, and in doing so to be free to name and to criticise members of the clinical team caring for their child. They said that the injunction was an illegitimate restriction of their freedom of speech. The NHS trusts concerned resisted the parents' applications, on the primary ground that making public the names of the treating clinicians would create an unacceptable risk of an invasion of their rights to private life, by exposing them to harassment and abuse of the type described above.

6. The courts below reached opposite conclusions about the parents' applications. At first instance, the President of the Family Division agreed with the trusts that the injunctions should not be discharged: [2021] EWHC 1699 (Fam); [2022] Fam 180. The Court of Appeal disagreed, and discharged the injunctions: [2023] EWCA Civ 331; [2023] Fam 287. Its order has been stayed pending the outcome of this appeal. While at first sight this disagreement might look like different judges taking different views about where the balance lay between the competing rights to freedom of expression and to a private life of the parents and the clinical team respectively, careful inspection of their reasoning reveals significant differences between them as to the principles to be applied. Furthermore, although both the courts below agreed that the court had jurisdiction (in the sense of power) to grant the injunctions and to continue them after the proceedings had concluded, the parents maintain a challenge to the existence of that jurisdiction, in particular in cases like the present where the injunctions were granted, and maintained in force after the proceedings had concluded, on the application of the trusts themselves, rather than by the clinicians thereby protected.

7. Resolution of those issues has led this court into the need to review from first principles the practice of the making and continuation of injunctions of this kind. In some respects the court has looked beyond the arguments originally advanced by the parties in their written cases, but not without inviting submissions on those wider concerns. This is in particular because, after the hearings in the courts below and the preparation of the parties' written cases, this court conducted a fundamental review of the court's power to grant injunctive relief, albeit largely outside the human rights context, in *Wolverhampton City Council v London Gypsies and Travellers* [2023] UKSC 47; [2024] AC 983

("*Wolverhampton*"). The principles which govern the grant and continuation of injunctions apply to all Divisions of the High Court.

2. The background facts

8. We take this account of the facts preceding the discharge applications mainly from the first instance judgment of Sir Andrew McFarlane P.

(1) The Abbasi case

9. Zainab Abbasi was born in 2013 with a rare and profoundly disabling neurodegenerative disease, to which was added lung damage as the result of her contracting swine flu in 2016. For most of her life she was treated in hospital under a mainly palliative treatment plan delivered by Newcastle upon Tyne Hospitals NHS Foundation Trust ("the Newcastle Trust"). Both of Zainab's parents are medically qualified, and they disagreed with the restriction in Zainab's care plan to palliative care, considering that more active care would be appropriate. The parents also became increasingly critical of the overall care regime under which the hospital's paediatric intensive care unit operated and the way in which care was delivered to their daughter by individual staff members. Matters deteriorated to the extent that the hospital sought to prohibit Zainab's father from attending the ward and, when he did so, the police were called and he was forcibly removed.

10. The Newcastle Trust issued proceedings in the Family Division in August 2019. The respondents were Zainab herself, by her CAFCASS guardian, and her parents. All the parties' names were anonymised from the outset. The Trust sought a declaration that it was in Zainab's best interests that life-sustaining treatment should be withdrawn. It also sought an injunction to prevent the identification of persons and institutions involved in Zainab's treatment until the proceedings had been concluded, pointing to recent cases of a similar nature which had attracted interest from campaigning groups and from individuals who behaved badly during the proceedings, with social media threats to medical and legal professionals involved. The Trust stated that if something similar happened, it would adversely affect not only the care provided to Zainab but also the care provided to other children in the hospital. On 6 September 2019, at a hearing in private at which the Trust, Zainab's parents, Zainab's CAFCASS guardian and the Press Association were represented (having been given notice of the application), case management directions were given by MacDonald J for a full hearing on 19 and 20 September 2019. He also issued a temporary injunction, upon the detail of which nothing turns, and directed that all further attended hearings in the proceedings would be held in public.

11. The Trust then applied for a continuation of the injunction, relying on a statement from two of Zainab's doctors to the effect that without anonymisation it would be possible for the hospital, the treating team, Zainab and her family to be identified. It based its application on article 8 of the European Convention on Human Rights ("the Convention"), which protects the right to respect for private and family life, the home and correspondence. In that regard, the Trust relied on the article 8 rights of the persons in relation to whom the order was sought. On 12 September 2019 Lieven J issued an injunction, the main terms of which we set out below. The order was made without opposition following a public hearing at which the Trust, Zainab's CAFCASS guardian and the Press Association were represented.

12. The full hearing of the application for a declaration never took place because, sadly, Zainab died on 16 September 2019. The injunction was to have been reviewed at the main hearing, but as this did not take place it remained in force, in accordance with its terms, "until further order", save that the prohibition on naming the Trust lapsed upon the conclusion of the proceedings, on Zainab's death. On 31 July 2020 the injunction was varied by consent to permit naming the parties to the proceedings and the hospital where Zainab was treated, but it remained in force in relation to the names of the clinicians listed in the original order. Following the variation, the *Mail on Sunday* published a feature about the case, which was followed by coverage over a number of months by many national news organisations, including the BBC and other broadcasters.

13. Zainab's parents remain critical of the care received by their daughter, which they regard as symptomatic of a wider dysfunctionality affecting the Trust's paediatric intensive care unit. They wish to publicise their account of the treatment which she received, naming the relevant clinicians, so that they may bring about a more general investigation of the unit in the public interest.

(2) The Haastrup case

14. Isaiah Haastrup was born in February 2017. Due to clinical negligence he suffered oxygen deprivation during birth which led to grave damage to his central nervous system. The result was that he was permanently dependent upon a ventilator to sustain life, under intensive care at King's College Hospital NHS Foundation Trust ("King's"), which has settled the parents' negligence claim arising from the circumstances of his birth.

15. King's made an application in relation to Isaiah in August 2017, seeking a declaration that the withdrawal of life-sustaining treatment was in his best interests, and joining Isaiah by his CAFCASS guardian, and his parents. All the parties' names were anonymised. On 10 and 17 August 2017 the identities of Isaiah's parents and the name of the hospital where Isaiah was being treated were reported in a newspaper. In early October 2017 the Trust was contacted by the BBC, which wanted to make a programme about the

proceedings. The Trust then sought an order preventing the publication of any material which might identify those who had cared for, or were at the time caring for, Isaiah or his mother, the authors of second opinions, and the clinicians with whom the Trust had liaised over a possible transfer of Isaiah to another hospital. The application was advanced on the basis that the Trust was concerned for the welfare of the clinicians who formed the subject of the proposed order, were they to be identified. That, it was said, could lead to the care provided to Isaiah and other patients being compromised, as well as an intrusion into the privacy of the individuals concerned. The Trust based its application on the article 8 rights of those it sought to protect.

16. On 6 October 2017 MacDonald J issued an injunction in relation to the proceedings, following a hearing in private at which the Trust and the Press Association (which had been given notice of the application) were represented. Isaiah's parents and the BBC both indicated that they did not wish to oppose the application. The order was in different terms from that made in Zainab's case. We will summarise the relevant differences later. It was expressed to have effect during Isaiah's lifetime, and thereafter until further order.

17. The application relating to Isaiah went to a full hearing in January 2018 before MacDonald J. The hearing was held in private, but accredited representatives of the media were present. In a judgment handed down on 29 January 2018 the judge made the declaration sought by the Trust: *King's College Hospital NHS Foundation Trust v Thomas* [2018] EWHC 127 (Fam); [2018] 2 FLR 1028. The judgment disclosed the identities of Isaiah, his parents, the Trust and the hospital where Isaiah was being treated, but anonymised the clinicians who gave oral evidence or whose witness statements or reports were before the court. Some of those clinicians were involved in Isaiah's treatment. Others had been commissioned to provide reports during the course of his treatment. One clinician had provided a second opinion but had no input into Isaiah's care. After a stay pending an unsuccessful application for permission to appeal (*In re H (A Child)* [2018] EWCA Civ 287), and an application to the European Court of Human Rights ("the European court") which was ruled inadmissible on 6 March 2018 (Application No 9865/18), Isaiah's life-sustaining treatment was discontinued on 7 March 2018 and he died later the same day.

18. The case was the subject of national media coverage between February and May 2018, in which the hospital was named. In July 2020 an inquest was opened into the circumstances of Isaiah's death. It resulted in further newspaper coverage until September 2020. The inquest was mainly focused upon the circumstances of Isaiah's birth. It was adjourned pending resolution of the continuing effect of the injunction upon the conduct of the inquest.

19. Isaiah's parents wish to speak publicly about what happened in connection with their child's birth and death, but the injunction affecting them protected the identity of the

treating clinicians at both birth and death. They have serious criticisms to make of the clinical care provided on both occasions, and more generally of the Trust's palliative treatment plan.

(3) The terms of the orders

20. The injunctions differed in significant respects, only in part because of the different contexts in which they were made.

(i) The Abbasi injunction

21. The injunction issued on 12 September 2019 in the Newcastle Trust case ("the Abbasi injunction") prohibited the publishing or broadcasting of the embargoed information in "any newspaper, magazine, public computer network, internet website, social networking website, sound or television broadcast, any cable or satellite programme service".

22. The embargoed information was any material, information or picture "that identifies or is likely to identify: (1) Zainab, who is the subject of these proceedings, and/or (2) any member of Zainab's family, and/or (3) any person caring for Zainab, and/or (4) any doctor or other medical professional caring for Zainab, and/or (5) where any person listed above lives, (6) any institution at which Zainab is treated or cared for, and (7) the applicant NHS Trust, whose details of which (sic) appear in the record of information appended to this order". The record of information appended to the order listed Zainab, her parents, the hospital where Zainab was treated, the Newcastle Trust, and four clinicians. Thus, despite the wide language of the order, it did not extend to "any person caring for Zainab", or "any doctor or other medical practitioner caring for Zainab", because the record of information restricted those categories to the four named clinicians. The effect of the injunction was to keep anonymous Zainab herself, her parents, the Newcastle Trust and the particular hospital premises in which she was being treated, and four named members of her clinical team, all at the consultant level of seniority.

23. The injunction was expressed to bind the following categories of persons: "(1) the parties and their representatives, (2) the witnesses, (3) all persons who attend all or any part of an attended hearing, (4) all persons who by any means obtain or are given an account or record of all or any part of an attended hearing or of any order or judgment made or given as a result of an attended hearing, (5) all persons who are provided with or by any means obtain documents and information arising from this application, and (6) any body, authority or organisation (and their officers, employees, servants and agents) for whom any such person works or is giving evidence".

24. The injunction contained carefully drafted permissions designed to enable information to be disclosed for the purposes of caring for Zainab and to permit the publication of information relating to any other public hearing in a court (including a coroner's court) in which no injunction was issued. It also permitted anonymised reporting or commenting on the Abbasi case. It was expressed to continue until further order, save that the anonymisation of the name of the treating hospital was to end with the conclusion of the proceedings, and subject also to a planned review of the injunction at the conclusion of the proceedings, by then listed for a final hearing on 19 and 20 September 2019.

25. As already noted, there was no review of the injunction at the end of the final hearing as contemplated by its terms, because Zainab died before the hearing could take place. However, it was varied by consent in July 2020 so as to preserve anonymity thereafter only for the four named members of the clinical team. This was the form which it took when the parents' application to discharge it was made.

(ii) The Haastrup injunction

26. The injunction issued on 6 October 2017 in King's case ("the Haastrup injunction") contained a similar restraint on publication, but the embargoed information was different. It prohibited disclosure of "the name and/or personal details of: (1) the applicant's clinical staff involved in the care of [Isaiah and his mother] during [her] ante-natal care and labour and [his] delivery, (2) the applicant's clinical and nursing staff who have cared and continue to care for [Isaiah] since his birth, (3) the applicant's non-clinical staff who have cared and continue to care for [Isaiah] since his birth, (4) any clinician who has provided a second opinion or advice to the applicant regarding [Isaiah's] diagnosis, prognosis, treatment and management, and (5) any clinician whom the applicant's clinical staff have consulted and/or communicated with regarding a possible transfer of [Isaiah] to another hospital", together with "any picture … of the above" and "any other material likely or calculated to lead to the identification of the above".

27. The Haastrup injunction contained a simpler statement of who was to be bound by it, namely "all persons and all companies (whether acting by their directors, employees or agents or in any other way) who know that the order has been made". It also contained a simpler duration provision, namely during Isaiah's lifetime and then until further order. There was no provision for review of the injunction at the end of the proceedings, although there was liberty to apply to vary or discharge it on 48 hours' notice.

28. The main difference between the two injunctions was therefore that the Haastrup injunction anonymised a much wider class of clinical and non-clinical staff than the Abbasi injunction. It protected not only all clinical, nursing and non-clinical staff involved in Isaiah's care, but also all clinical staff involved in his mother's ante-natal care

and his delivery. In addition, it protected any clinician who had provided a second opinion or advice to the Trust regarding Isaiah's diagnosis, prognosis, treatment and management, and any clinician whom the Trust's clinical staff had consulted or communicated with regarding a possible transfer of Isaiah to another hospital. Only a few of the clinicians protected by the injunction subsequently gave evidence in the proceedings. Unlike the Abbasi injunction, the order contained no specification of the individuals who were to be anonymised. Unlike the Abbasi injunction, it did not prevent the identification of the child or his parents. Nor did it prohibit the identification of the Trust or of the hospital where Isaiah was being treated.

3. The discharge applications

29. Zainab's and Isaiah's parents made applications in their separate proceedings for the discharge of the injunctions in August 2020. Zainab's father, Dr Rashid Abbasi, is himself a consultant respiratory physician with over 24 years' experience of working in the NHS. Zainab's mother, Dr Aliya Abbasi, is also a doctor. In the father's statement, he noted that end of life care was a sensitive area which had given rise to public concern and controversy. Arguments had been made for a reform of the law. It was in the public interest for the public to know the facts. There were lessons to be learned from Zainab's case, for the public and for the medical profession. He and his wife had observed unprofessional and unethical behaviour by some of their medical colleagues. Some of the clinicians had been reluctant to treat Zainab's respiratory disorder, although it was treatable, because of her underlying neuro-degenerative condition. They had failed to provide optimal care. To substantiate their concerns, the Abbasis needed to be able to name the individual clinicians they believed to be responsible. Zainab's father also wished to publicise an audio-recording of his and his wife's meeting with the clinical team, at which clinicians had attempted to pressurise them into agreeing to a withdrawal of life support. They also wished to be able to respond to allegations made against them by clinicians which had been reported in the media, by placing matters in context and explaining the background difficulties between certain clinicians and themselves. Zainab's father emphasised that he and his wife only wanted to voice concerns about the professional conduct of certain clinicians involved in Zainab's treatment. He acknowledged that no-one should invade the private lives of those clinicians. He also produced evidence about the widespread news coverage of the case following the variation of the injunction, as described in para 12 above.

30. Statements by Isaiah's father, Mr Haastrup, explained that the Haastrup injunction was preventing the press from reporting fully on the inquest which was proceeding into Isaiah's death, and which was being held in public. Particularly since King's had admitted liability in negligence for the events surrounding Isaiah's birth, the order should not act as a barrier to the reporting of matters of legitimate public concern. His purpose was not to "name and shame", but he wished to be able to speak openly about the matter, and for the media to be able to report on the circumstances and those involved. Public bodies such

as the NHS should not be shrouded in secrecy. Clinicians should not have a special status beyond that of other public servants. Enough time had passed.

31. The Trusts made cross-applications that new injunctions be granted in substantially the same terms, should the parents' applications succeed. The Trusts relied on statements from a registrar for the Royal College of Paediatrics and Child Health, a consultant in intensive care medicine on behalf of the Faculty of Intensive Care Medicine, the paediatric adviser to the NHS Practitioner Health Programme, the head of legal services at the Royal College of Nursing, the medical director and deputy chief executive of the Newcastle Trust, the clinical director of child health at King's, and the president of the Paediatric Critical Care Society. There was no focus on, or evidence relating to, any individual clinicians or health care providers.

32. The main points made in the statements were the following. In some recent cases of this kind – particularly the cases of Charlie Gard (*Great Ormond Street Hospital for Children NHS Foundation Trust v Yates (No 2)* [2017] EWHC 1909 (Fam); [2017] 4 WLR 131) and Alfie Evans (*Evans v Alder Hey Children's NHS Foundation Trust* [2018] EWCA Civ 805; [2018] 2 FLR 1269) – social media groups had been set up which had allegedly subjected the medical professionals to verbal abuse on social media. Some members of the public had staged protests outside the hospitals, and in some instances had allegedly made threats to hospital staff. This caused staff to suffer anxiety and distress, and was liable to disrupt the quality of care provided to patients. We note that the evidence produced in relation to the Gard and Evans cases concerned events during the children's lifetimes, while the hospitals were seeking declarations that life-sustaining treatment could be withdrawn, and in circumstances where it was known where the children were being treated. The statements also expressed concern that doctors and nurses might be discouraged from entering specialisms where there was a particular risk of exposure to the media if there was no restriction on reporting in difficult cases.

33. The Newcastle Trust also produced evidence about the news coverage following the variation of the Abbasi injunction, described in para 12 above, and about comments by members of the public on news media platforms. The comments did not threaten any harassment or other unlawful behaviour. There was no suggestion that the publicity had resulted in any problems for the hospital or its clinicians or other staff.

34. In support of King's application, evidence was produced of the media coverage of Isaiah's case, as described in paras 15 and 18 above. Evidence was also given that a social media group had set up a Facebook page called "Life for Isaiah Haastrup", on which some posts had described the withdrawal of life support as murder. Although the hospital where Isaiah was treated was named in the media both before and after his death, there was no suggestion that the publicity had resulted in any problems for the hospital or its clinicians or other staff.

35. In September 2020 Cobb J ordered that the applications and cross-applications should be heard together. They were duly heard together in early February 2021 and both were dismissed by Sir Andrew McFarlane P on 23 June 2021. By that time a year and nine months had passed since Zainab's death, and three years and three months since Isaiah's death.

36. It will be necessary to consider aspects of the President's reasoning in detail in due course, but its essence may be summarised as follows:

> (1) There could be no challenge at first instance to the court's jurisdiction to make the orders in the first place. They had been made years previously and not appealed. Although the proceedings in which they were made had for their main purpose come to an end, they remained on foot for the purpose of enabling applications to be made to discharge the orders, and for enabling the court to deal with those applications.
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> (2) The court's duty to act in accordance with Convention rights, under section 6(1) of the Human Rights Act 1998, required it to balance the article 10 and article 8 Convention rights of the parents and the treating clinicians as laid down in *In re S (A Child) (Identification: Restrictions on Publication)* [2004] UKHL 47; [2005] 1 AC 593 ("*In re S*"). Article 10 protects the right to freedom of expression.
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> (3) That balance came down firmly in favour of the prioritisation of the article 8 rights of both groups of treating clinicians over the article 10 rights of the parents, in particular because of the body of evidence before the court that the risk of abuse and harassment of treating clinicians in cases of this kind was likely to cause damage to their mental health and wellbeing, to their morale and to their commitment to continuing with this type of work, to the detriment of the public interest in the integrity and ability to function of their clinical group, to recruitment and retention, and to the ability of the Trusts to carry out their vital work in the intensive care of gravely ill children.

37. The parents appealed to the Court of Appeal. The Royal College of Nursing, the British Medical Association, the Faculty of Intensive Care Medicine, the Royal College of Paediatrics and Child Health and the Paediatric Critical Care Society took part in the appeal as interveners (as they have also taken part in the present appeal). Following a hearing before Lord Burnett of Maldon LCJ, King and Carr LJJ in November 2022, the judgment of the court was handed down at the end of March 2023, allowing the appeals and discharging the injunctions. By then Zainab had been dead for three and a half years and Isaiah for just over five years. It will be necessary to review the detail of parts of the reasoning of the Court of Appeal, but it may be summarised as follows:

(1) The High Court had inherent jurisdiction, exercising parens patriae powers, to make orders to protect those engaged in, affected by or connected with the proceedings before it and to protect the integrity of the proceedings themselves. That jurisdiction was exercised, so far as Convention rights were concerned, by reference to those rights. There could be no doubt that it had jurisdiction to make, continue, vary or discharge injunctions restraining publicity during proceedings of this kind, as well as after their conclusion. It was unnecessary for the applicant for an injunction to show a separate cause of action in order to found jurisdiction to grant an injunction.

(2) The passage of time since the two children's deaths and the effective end of the proceedings greatly reduced the risk of abuse or harassment of the clinical staff if their identities were revealed, while the more general concerns of the Trusts about adverse effects upon staff cohesion, morale, retention and recruitment were an inappropriate basis for interference with the parents' article 10 rights to freedom of expression, or for conferring indefinite anonymity upon those involved in cases of this kind. Such anonymity was a matter for Parliament rather than the courts.

(3) Accordingly, the risk of invasion of the clinicians' article 8 rights came nowhere near justifying the continued impediment to the parents' rights under article 10, so long after the end of the proceedings.

4. The context, nature and purposes of such orders

(1) The context

38. It is important to start the analysis of injunctions of the present kind by focusing upon the type of proceedings in which these orders come to be made. In proceedings of this kind the High Court is exercising its inherent jurisdiction as parens patriae, that is, it is performing the Crown's residual function of protecting those who stand in need of protection. The court's primary responsibility in exercising that jurisdiction in such cases is to decide which among available alternatives in medical treatment will serve the best interests of the child concerned. It is not acting simply as an adjudicator between the competing rights and obligations of the parties in an essentially adversarial contest between them. As Viscount Haldane LC explained in *Scott v Scott* [1913] AC 417, 437, in relation to the parens patriae jurisdiction over wards of court and incapacitated adults:

> "There the judge who is administering their affairs, in the exercise of what has been called a paternal jurisdiction delegated to him from the Crown through the Lord Chancellor, is not sitting merely to decide a contested question … the court is really sitting primarily to guard the interests of the ward or

> the lunatic. Its jurisdiction is in this respect parental and administrative, and the disposal of controverted questions is an incident only in the jurisdiction."

Those observations are equally applicable where the child is not a ward of court, but is otherwise under the court's protection exercising its parens patriae powers: see, for example, *In re M and N (Minors) (Wardship: Publication of Information)* [1990] Fam 211, 223.

39. There is therefore not a claimant and one or more defendants in the usual sense, each pursuing their own interests in competition with each other. But there are of course parties to the proceedings. They are commenced because someone (usually the hospital entity, here two NHS trusts) has brought the need for a decision as to the withdrawal of life-sustaining treatment to the attention of the court. The respondents are normally the parents or guardian of the child, any other person who has an interest in or relationship to the child, and the child, represented by a guardian who is independent of both the trust and the parents with whom the trust may be in dispute.

40. Although the proceedings are therefore not fundamentally adversarial, there may well be clearly formulated alternative courses for the child's care to be chosen between by the time the proceedings start, each of which may be supported by detailed submissions, backed up by evidence, including medical opinion. And if there are in reality just two choices, between continuing with or ending life support, there will frequently be both the appearance and the reality of an adversarial contest between the proponents of those two alternatives.

41. Nonetheless, the court is being called upon to intervene in the care of the child by another entity, the trust, already charged with and exercising that care. The court's task is to decide how that care should be discharged in the best interests of the child. In these circumstances, the question whether or not to grant an injunction at the outset of the proceedings is bound to be affected by the natural desire of the court to minimise the risk of collateral damage which publicity about the proceedings may cause to the medical care being provided by the trust; all the more so if that damage is threatened to be caused by unlawful activity in the form of abuse and harassment by persons as yet unknown. It is natural for the trust as applicant to wish to alert the court to that risk, both because it may adversely affect its care for the child and for other children in its care with similar needs, and also because as employer of the staff involved it wishes them to be protected against the risk of harm arising from the publicity which the proceedings may otherwise attract.

42. A second important aspect of the context is that the proceedings generally have to be conducted with some urgency. There may be a limited time in which to make a choice between different treatment regimes. The child may be in pain or distress which the trust

is struggling to relieve. But there may be a need for intense preparation of evidence (including medical opinion) before a hearing, to enable the court to make an informed choice. The point of this aspect of the context is that the parents in this appeal were critical of the use of evidence about the risks of abuse and harassment drawn from earlier cases, rather than evidence concerning the particular factual circumstances of the case before the court. But it is for cautious consideration to what extent the parties can be expected to devote significant time and effort to the preparation of evidence and submissions about an injunction, when struggling to prepare for the determination of the life or death question which the proceedings have been issued to have speedily resolved. We return to this below.

43. The urgency which attends the commencement and hearing of the proceedings is matched by the suddenness of their likely end, generally upon the death of the child. This may occur at any time if the child dies before the court has given its decision, and is likely to occur shortly after a decision that life support should be withdrawn, if (in the absence of an appeal) the child's death follows as the natural consequence. But if an injunction has been granted which is not by its own terms expressed to cease to have effect when the proceedings end, or after a specified period thereafter, the consequence is that a permanent restriction of disclosure remains in place, detached from the proceedings to which it was ancillary as a mechanism for avoiding collateral damage, and from the treatment which it was designed, at least in part, to protect from the deleterious effects of publicity. Furthermore, after the child has died, parens patriae powers can no longer be exercised. If the injunction is to be continued, it must be on some other basis. And at that stage, if not earlier, it may well be reasonable to expect any application for the continuation of the order to be supported by evidence concerned specifically with the circumstances of the case before the court.

44. Something more can usefully be said about the harm typically said to be threatened by publicity being given to the proceedings, if the clinicians involved in the underlying care are not anonymised. The first point is that, to the extent that the harm consists of abuse directed at members of the clinical team treating the child, or other clinicians involved in giving advice about treatment, it will generally be impossible to know in advance which members of the public will be tempted into such conduct, and impossible to know even after the event, where the abuse takes the form of anonymous messages on social media.

45. A second point to note is that the harm liable to be caused by such abuse may fall into a number of distinct legal categories. First, it may result in damage to the quality of the hospital's care for the relevant child, and possibly others being cared for in the same unit. Such damage will be contrary to the interests and rights of the relevant child, and it may also be an interference with the hospital trust's performance of its statutory functions. Secondly, the abuse may constitute an infringement of such rights as members of the clinical team have to be protected from such behaviour under the common law (eg of

defamation, trespass or assault) and statute (eg under the Protection from Harassment Act 1997), and in accordance with their Convention rights.

46. It is reasonable to infer that the risk of such harm is likely to decline over time, from the moment when the proceedings end. If the child dies before a decision has been issued or as a consequence of the court's granting the declaration sought, then media and social media interest can generally be expected to decline, as there is no longer any prospect of saving the child's life (it can equally be expected to decline if the court refuses to grant the declaration sought, or if, contrary to expectation, the withdrawal of life support does not result in the child's death). Although the parents will continue to grieve, the emotional reaction of the general public is unlikely to be as strong, especially if publicity was restricted while the child was being treated. There was no evidence before the courts below, when dealing with the applications for the discharge of the orders, to suggest otherwise. By contrast, the effect of the restraint upon the parents' freedom of expression is likely to be much more enduring in its consequences. The sense of injustice engendered by being prohibited from speaking freely about the loss of their child may well be lifelong in its effect.

47. A third point to note is that the harm which the child may suffer if the treatment provided is deleteriously affected by abuse of the clinical team, and the harm which the trust may suffer if its ability to care for the child, or for other children in its care, is deleteriously affected by such abuse, are both entirely consequential on harm suffered by the clinicians themselves. There is therefore an overlap between the child's interests, the interest of the trust in preserving the anonymity of the clinicians so as to avoid the adverse impact which abuse of them would have upon its provision of care to its patients, and the interest of the clinicians in preserving their own anonymity, so as to avoid violations of their rights. That overlap has an important consequence: by protecting its own interest in the anonymity of the clinicians, the trust can also incidentally protect the clinicians' private lives; and, so long as the child continues to live, the court can do the same by protecting the interests of the child. The trust, and the court, can thus protect the private lives of the clinicians without necessarily concerning themselves directly with the clinicians' rights. The clinicians' rights can, of course, also be asserted directly, as we shall explain.

(2) The nature of the orders

48. It is also important to understand the nature of such orders. First, they are injunctions contra mundum. Although they are addressed in part to named individuals and to individuals who, although unnamed, are capable of being identified, they are also directed to the world at large.

49. Secondly, the orders bind individuals and organisations who are not themselves likely to commit any act which infringes the rights of others. For example, the child's parents, and media outlets which may report the proceedings, are bound by the orders regardless of whether they are themselves likely to abuse or harass the clinicians involved in the care of the child. The absence of a cause of action against a defendant is not in itself an insuperable objection to the granting of an injunction, as was explained in the *Wolverhampton* case at paras 43-49 and 153. An analogy can be drawn, for example, with *Norwich Pharmacal* and *Bankers Trust* orders (see respectively *Norwich Pharmacal Co v Customs and Excise Comrs* [1974] AC 133 and *Bankers Trust Co v Shapira* [1980] 1 WLR 1274), and more particularly with internet blocking orders (see *Cartier International AG v British Sky Broadcasting Ltd* [2018] UKSC 28; [2018] 1 WLR 3259), discussed in *Wolverhampton* at paras 47-49 and 160-164. Like internet blocking orders, these injunctions can bind individuals, despite there being no cause of action against them, where that is the only effective way of protecting the interests which the order is designed to protect, whether those are the interests of the child, or the interests of the trusts in being able to perform their statutory functions without interference, or the interests of the clinical staff involved in the child's treatment.

50. Thirdly, expanding upon a point made in para 3 above, although orders of the present kind typically have the effect of restraining the publication of information about the proceedings in which they are made, they are primarily designed to restrain the publication or communication of information about events occurring outside the court, and about individuals who may not have participated in the proceedings. For example, the Abbasi injunction prohibited the publication of any information which was likely to identify the four clinicians listed in the appendix to the order or where they lived, although the only hearings to have taken place in court concerned case management directions and the granting of the injunction. The Haastrup injunction prohibited the identification of the clinical staff involved in the care of Isaiah and his mother during her ante-natal care and labour, although the court proceedings were not concerned with her or Isaiah's treatment at that time. It also prohibited the identification of any clinical, nursing or non-clinical staff involved in Isaiah's care, regardless of whether such persons gave evidence or were named in the proceedings.

51. Such injunctions are wider in scope than reporting restriction orders as ordinarily understood, which restrict the reporting of court proceedings (for example, by prohibiting the publication of the name of a witness). They are also different in that they are made in proceedings that are usually held in private. In other words, unlike reporting restriction orders, they do not necessarily make inroads upon the open justice principle (a matter to which we will return). For all these reasons, it appears to us to be confusing and potentially misleading to describe these injunctions as reporting restriction orders.

(3) The purposes of the orders

52. We have already identified a number of purposes for which orders such as the Abbasi and Haastrup injunctions have been sought: to protect the clinical team currently treating the child from the risk of abuse and harassment at their place of work, at home and on social media; to prevent the impact of such abuse and harassment of the clinical team having an adverse effect on the treatment of the child in question and possibly also on the treatment of other children who are patients in the same unit; to provide similar protection to clinicians involved in the ante-natal care and labour of the child's mother; to provide similar protection to clinicians involved in providing a second opinion to the treating clinicians; to provide similar protection to clinicians involved in consideration of a possible transfer of the child to another hospital; and to prevent such abuse and harassment from having an adverse impact on the recruitment and retention by trusts of clinical staff who work in paediatric intensive care units. It will be necessary to consider at a later stage whether all of these purposes are legitimate reasons for issuing injunctions of this kind, and for maintaining them in force after the child has died; how they relate to questions of standing; and their weight when balanced against the competing rights of those, including the parents and the media, whose freedom of expression is restricted.

5. The law governing such orders – jurisdiction and standing

53. In relation to the law governing the making and continuation of such orders, it is necessary at the outset to establish answers to the following questions: (1) whether, and if so on what basis, the court has jurisdiction to make such orders at the outset of the proceedings, and to continue them in force after the proceedings have ended; and (2) who has standing to seek such orders at the outset of the proceedings, and to seek their continuation in force after the proceedings have ended. It is also necessary to consider the contention that such orders are incompatible with the principle of open justice. Once those preliminary but essential points have been clarified, it will then be possible to consider other aspects of the law.

(1) Jurisdiction at the outset of the proceedings

54. Some of the issues we are about to discuss were not the subject of detailed consideration in the courts below but would nevertheless benefit from clarification. The injunctions were initially granted without opposition. At the stage when the question arose whether they should be discharged or new injunctions granted, following the children's deaths, the President was not hearing an appeal against the grant of the injunctions at the outset of the proceedings, but proceeded on the assumption that jurisdiction to make such orders existed. He also considered that the court must have jurisdiction to continue or discharge injunctions which were currently in force, and that that jurisdiction had to be exercised in accordance with section 6(1) of the Human Rights Act, with the consequence that the court had to balance competing considerations under articles 8 and 10 of the Convention. The Court of Appeal considered that the court had inherent jurisdiction to grant the injunctions exercising its parens patriae powers. Its jurisdiction had to be

exercised in accordance with section 6(1) of the Human Rights Act, so far as Convention rights were concerned. Having granted the orders, the court also had jurisdiction to consider whether to continue or discharge them, and again had to act in accordance with section 6(1) of the Human Rights Act.

55. Before this court, the Trusts' submissions proceeded on the basis that where the court has jurisdiction to grant an injunction under section 37(1) of the Senior Courts Act 1981, and to continue it in force, that jurisdiction, taken together with section 6(1) of the Human Rights Act, provides a basis for granting injunctions and maintaining them in force where required by article 8 of the Convention. On behalf of the parents, it was submitted that, although the power conferred by section 37(1) of the Senior Courts Act is theoretically unlimited, it is only exercised in accordance with established principles. Applying those principles, it was submitted, (1) the High Court has no power under the inherent jurisdiction to issue contra mundum injunctions restricting publicity in relation to proceedings held in open court, whether exercising parens patriae powers or in order to secure the administration of justice, (2) it has no power to issue injunctions on the application of the Trusts in order to protect the privacy interests of third parties, (3) article 6 of the Convention (which guarantees the right to a fair trial) does not permit a court to derogate from the open justice imperative for the benefit of people who are neither parties nor witnesses in the proceedings, and (4) the power which the courts purported to exercise to interfere with freedom of expression was not "prescribed by law" for the purposes of article 10(2) of the Convention.

(a) The parens patriae jurisdiction

56. We shall begin by considering the High Court's jurisdiction to exercise the prerogative powers of the Crown as parens patriae. That jurisdiction enables the court to protect those who cannot protect themselves. It was described by Lord Cottenham LC in *In re Spence* (1847) 2 Ph 247, 252; 41 ER 937, 938, in a passage cited with approval by Lord Halsbury LC in *Barnardo v McHugh* [1891] AC 388, 395:

> "This court [ie the Court of Chancery] interferes for the protection of infants, qua infants, by virtue of the prerogative which belongs to the Crown as parens patriae, and the exercise of which is delegated to the Great Seal."

The jurisdiction is accordingly equitable and inherent in the High Court, which has inherited the equitable jurisdiction formerly exercised by the Court of Chancery. Although many of the authorities on the parens patriae jurisdiction are concerned with wardship, it is not a precondition of its exercise that the child has been made a ward of court.

57. The court's parens patriae powers provide a source of jurisdiction, in cases of the present kind, to grant an injunction contra mundum restraining the publication of information, if that is necessary in order to protect the interests of the child. Since the child's rights to privacy and confidentiality are protected by article 8 of the Convention, and since any competing interests of the parents and the media in freedom of expression are protected by article 10, it follows that the court is required by section 6(1) of the Human Rights Act to exercise its parens patriae powers compatibly with those rights (there being no suggestion that section 6(2), which disapplies section 6(1) where necessary to give effect to primary legislation, is applicable in the circumstances of these proceedings).

58. The court's ability to protect the interests of the child under its parens patriae jurisdiction is illustrated by the case of *In re C (A Minor) (Wardship: Medical Treatment) (No 2)* [1990] Fam 39, where the High Court gave directions in relation to the care of a terminally ill child and granted a contra mundum injunction restricting publicity. The Court of Appeal substituted a contra mundum injunction in different terms, prohibiting (1) the publication of the name or address or otherwise identifying the child, her parents, the hospitals at which she was being or had been treated, or any natural person having had or continuing to have her care, (2) soliciting information relating to the child or her parents from the parents, the staff of the hospitals, or the persons having had or continuing to have the care of the child, or (3) publishing such information obtained from such persons. The court added a schedule naming the child and the parties. As Balcombe LJ explained (p 52), with the agreement of Lord Donaldson of Lymington MR (p 49), this was "necessary … otherwise the persons to whom the order is addressed will not know whom it is they are restrained from identifying or soliciting". As in the present proceedings, it remained possible for the media to report all other information about the case, including the facts which were material to informed discussion of the ethical, legal and medical issues.

59. The court proceeded on the basis that such an injunction could be granted under the parens patriae jurisdiction to protect the interests of the child: both the child's welfare, and her right to the confidentiality of her medical treatment. The Master of the Rolls considered that the inherent jurisdiction to secure the administration of justice was also relevant (p 47).

60. The court's parens patriae jurisdiction enabled it to prohibit the identification of the child's carers, on the basis that media identification of those carers or inquiries as to their identity might affect the quality of the care provided (pp 47-48). It also empowered the court to safeguard the child's right to the confidentiality of her medical treatment, and for that purpose to prohibit the identification of those who had cared for her in the past or inquiries as to their identity (p 48). On the same basis, the court could also prohibit the identification of the hospitals where the child was being or had been treated, and the solicitation of information about the child from the staff of the hospitals (ibid). The court could also, on the same basis, prohibit the parents from disclosing information about the

child's treatment, and prohibit the solicitation of information about the parents from the staff of the hospitals (p 49). Nicholls LJ stated (pp 54-55):

> "Those who have the charge of baby C have, in all conscience, a task which is sufficiently difficult and emotionally draining without the pressures on them, as they carry out their work and make their medical decisions day by day, being increased by the massive personal publicity which would be likely in the absence of an appropriately framed injunction. The promotion of baby C's welfare requires that those caring for her should not have to cope with this additional burden. Nor, for the same reason, should they be faced with the additional burden of any comments from the parents which might be induced by the press.
>
> But baby C's interests do not stop there. Those who have previously been involved in her care, as social workers or as medical staff, owe a duty of confidence to her in respect of the information they have acquired about her and her background. Likewise, all the staff at the hospital where baby C is being cared for. Such information could not properly be disclosed by any of these individuals to the media. That being so, I can see no disadvantage and considerable advantage in this position being made abundantly clear, by the protective injunction being framed in terms which include a prohibition on soliciting such information from such persons and from publishing any such information."

61. The reasoning in *In re C* has been cited with approval in subsequent cases (eg *In re Z (A Minor) (Identification: Restrictions on Publication)* [1997] Fam 1, 23-25), and the order made in that case has served, with some refinements, as the model for similar orders. In *In re S (A Child) (Identification: Restrictions on Publication)* [2003] EWCA Civ 963; [2004] Fam 43 Hale LJ concluded, after reviewing the authorities, that such orders can be justified either on the basis that they are necessary to protect the interests of the child or on the basis that they are necessary to protect the administration of justice in proceedings in which the court has intervened to protect the interests of the child. She said (para 36):

> "If the court has intervened, through wardship or other proceedings, in order to safeguard and promote the welfare of the child, and that objective will be jeopardised by the proposed publicity, then this might be said to threaten the effective working of the court's jurisdiction. The alternative approach,

> taken in *In re* Z [1997] Fam 1 with the approval of Sir Thomas Bingham MR, was to accept that safeguarding the welfare of a child whose future is already before the court is an alternative basis for making such an order. In either event, it is clear that the information must relate to the child or his carers and that its disclosure would be harmful to him."

The last sentence in that passage is important. The court's power to prohibit the publication of information about the child's carers, as derived from its parens patriae jurisdiction or alternatively from its jurisdiction to ensure the effectiveness of its orders in respect of the child's treatment, is based on the need to prevent interferences with the ability of the carers to care for the child. It is not based on concern for the carers' rights or interests for their own sake.

62. Considering the orders granted in the present proceedings in the light of this discussion, it will be recalled that the Abbasi injunction prohibited the publication of information identifying the child, her parents, the hospital where she was being treated, the Newcastle Trust, and four clinicians who were caring for her. The court had jurisdiction to grant such an injunction in the exercise of its parens patriae powers, if it was necessary for the protection of the child's interests, including her welfare, her right to confidentiality and privacy, and her Convention rights (as distinct, so far as this ground of jurisdiction is concerned, from the protection of the clinicians, the hospital or the Trust, except in so far as that was necessary for the protection of the child's interests). The prohibited information was within the scope of the injunction granted in *In re C*, apart from the inclusion of the Trust; but a prohibition on the identification of the Trust would also fall within the scope of the parens patriae jurisdiction if it was necessary to protect the child's interests, as might well be the case (for example, if the identification of the Trust could lead to the identification of the hospital where the child was being treated).

63. As we have explained, the Haastrup injunction was wider. In the first place, it prohibited the disclosure of the names or personal details of all the clinical and non-clinical staff who had cared or continued to care for the child since his birth. That information was within the scope of the injunction granted in *In re C,* and the prohibition on its disclosure was within the court's parens patriae jurisdiction, in order to protect the child's right to confidentiality and privacy. For the same reason, there was jurisdiction to grant a similar injunction in respect of clinicians who had provided a second opinion or advice to King's regarding the child's diagnosis, prognosis, treatment and management. Such clinicians must have been provided in confidence with information about the child's medical condition and treatment, which (as they can be taken to have known) the Trust itself held subject to a duty of confidence which it owed to the child. When it was disclosed to the external clinicians, their resultant duty of confidence was consequently owed to the child, as well as to the Trust. The same might well also apply to any clinicians with whom the Trust had communicated regarding a possible transfer of the child to another hospital.

64. On the other hand, in so far as the Haastrup injunction prohibited the disclosure of the names and details of the clinical staff involved in the care of the unborn child and his mother during her ante-natal care and labour, it could not be justified on the basis of a duty of confidentiality owed to the child: while the child was in utero, the clinicians stood in a confidential relationship only to his mother (and she was entitled to waive their duty of confidentiality). It is not obvious, and it has not been argued, that the child's right to be protected against an invasion of privacy would extend to his mother's pregnancy and labour. Whether there was jurisdiction to grant such an injunction on the basis that it was necessary to protect the welfare of the child, or to secure the administration of justice, would depend on whether the identification of the clinicians who had previously treated the mother was likely to have a significant impact on the continuing treatment of the child. That might well have been the position on the facts at the time when the injunction was granted, given the link between the negligence at the time of Isaiah's birth and the events that followed.

65. Finally, in relation to the parens patriae jurisdiction, we should note a point arising in relation to the duration of the injunctions. As we have explained, an injunction granted under parens patriae powers can provide clinicians with anonymity, so as to prevent the harmful effects which publicity might have upon the care which they provide to the child. However, the jurisdiction is available only as long as the child is alive; and the risk of a social media furore, in cases of the present kind, may continue after the child's death, at least for a time. There is therefore a risk that an injunction granted under the parens patriae jurisdiction may cease to provide the protection needed both by the trust, if there are other gravely ill children being treated by the same clinicians, and by the clinicians themselves, if the child dies during the course of the proceedings or within a short time of a decision approving the withdrawal of life support.

66. That risk can be avoided by fixing the duration of the injunction so that it remains in force for a period of time after the end of the proceedings, which we refer to below as a cooling-off period. That will allow time for the trust to seek a continuation of the injunction, if that is necessary to prevent interference with its ability to treat its patients. The cooling-off period will also provide time for the clinicians themselves to seek an injunction on the basis of their own right to privacy, if they have not already done so, and if an order continues to be necessary. The extension of the original injunction into a cooling-off period can be justified under the *Broadmoor* jurisdiction discussed below (ie the jurisdiction established in the case of *Broadmoor Special Hospital Authority v Robinson* [2000] QB 775) on the basis that it is necessary in order to enable the trust to fulfil its responsibilities towards the other gravely ill children under its care. The extension of the injunction can also be justified on an equitable basis, as the original order has the practical effect of protecting the interests of the clinicians, and time should therefore be allowed for them to take steps for their continued protection before the existing protection is withdrawn. The cooling-off period should accordingly be of sufficient duration to enable the trust to apply for a continuation of the injunction, and to enable the clinicians to join the proceedings if they consider that to be necessary.

(b) The Broadmoor jurisdiction

67. A second potential source of jurisdiction, discussed in *Wolverhampton* at para 45, is the court's power to grant injunctions on the application of public bodies acting under statutory (or, where they exist, common law) powers. A significant authority in this context is the case of *Broadmoor*. The defendant in the proceedings had been convicted of manslaughter and was a patient in a special hospital. He wrote a book in which he described how he had killed his victim and his justification for doing so. He also identified other patients and gave details of their offences and mental states. The hospital authority obtained an ex parte injunction restraining him from distributing the book and ordering him to deliver up, and cause his printers to deliver up, all copies of it. That injunction was discharged on the defendant's application, and the Court of Appeal (Lord Woolf MR, Morritt and Waller LJ) dismissed an appeal against that decision. However, a majority of the court upheld the existence of jurisdiction to grant an injunction on the application of the hospital authority where a defendant was interfering with the performance of its public responsibilities.

68. Lord Woolf MR stated (para 25):

> "if a public body is given a statutory responsibility which it is required to perform in the public interest, then, in the absence of an implication to the contrary in the statute, it has standing to apply to the court for an injunction to prevent interference with its performance of its public responsibilities and the courts should grant such an application when 'it appears to the court to be just and convenient to do so.'"

That dictum was cited with approval by Lord Dyson, giving the judgment of this court, in *R v Rollins* [2010] UKSC 39; [2010] 1 WLR 1922.

69. In *Broadmoor*, the hospital authority had statutory duties to treat its patients, to maintain the security of the hospital, and to provide a therapeutic environment. In Lord Woolf MR's view, as a consequence of those duties it had implicit rights or powers, which were not confined to what happened within the confines of the hospital (para 28):

> "… if it can be shown an activity is taking place outside the hospital the court may, if appropriate, grant an injunction to restrain that activity if it is an activity which can be shown to be having a sufficiently significant impact on the security of the hospital or the treatment of a patient … If … there were to be someone who was not a patient who was indulging in conduct, for example writing letters to patients, which was interfering

> with security or treatment in the hospital there would be jurisdiction to grant an injunction."

70. On the other hand, Lord Woolf MR considered that the hospital authority could not seek an injunction in order to protect its patients' rights to privacy or confidence, or those of the victim's family (para 30):

> "I would accept that the authority cannot bring proceedings to protect any patients' right to privacy or confidence. To protect other patients, the authority have to rely on the interference which the conduct of which complaint is made would have on the performance of their duties. In particular, the duty of the authority to maintain security, order and a therapeutic environment within the hospital. The position is the same with regard to the family of the defendant's victim … The powers and responsibility of the authority do not extend to providing the protection the family would like unless the conduct complained of affects the authority's responsibilities within the hospital."

On the facts, Lord Woolf MR concluded that the defendant's activities did not pose a substantial risk to the hospital authority's performance of its public responsibilities.

71. Waller LJ agreed with Lord Woolf MR's formulation of principle, quoted in para 68 above (para 55), and also agreed that it was not within the authority's powers to protect the confidentiality of its patients: "[t]o protect those confidences, proceedings would have to be by or on behalf of those patients" (para 54). On the facts of the case, Waller LJ considered that an injunction could not be granted, because the defendant's activity could not be regarded as interfering with the performance of the authority's public responsibilities.

72. Morritt LJ focused on the particular injunction sought, and concluded that the court had no jurisdiction to grant it. As the injunction would interfere with the defendant's exercise of his right of free speech and his proprietary right as the owner of the copyright in the book, the power to seek such an injunction could only be implied on the basis of a self-evident and pressing need. The necessity relied on was the hospital authority's power and duty to treat the defendant. But in that event the necessity would not be confined to publications by patients alone but would extend to publications by third parties. A power of such constitutional significance was not to be implied. Only Parliament could confer such a power, and it must do so in terms which admitted of no doubt as to its intention.

73. Those dissenting observations, and the fact that an injunction was refused in the *Broadmoor* case notwithstanding its striking circumstances, indicate a need for caution in relation to the grant of injunctions on the basis set out by Lord Woolf MR. That was also made clear in the later case of *H (A Healthcare Worker) v Associated Newspapers Ltd* [2002] EWCA Civ 195; [2002] EMLR 23, where the question was whether an injunction should be granted to prevent a newspaper from publishing the name of a health authority which had employed a healthcare worker who was HIV positive. The health authority argued that widespread alarm would be caused to patients, and that helplines and HIV testing and counselling would have to be provided, with significant administrative and resource implications. Reliance was placed on the dictum of Lord Woolf MR in *Broadmoor* cited at the end of para 68 above.

74. The Court of Appeal (Lord Phillips of Worth Matravers MR, Judge and Carnwath LJJ) accepted the argument based on the impact on patients, but stated, in relation to the argument based on the impact on the authority's administration and resources, that they "would view with concern any attempt to invoke the power of the court to grant an injunction restraining freedom of speech merely on the ground that release of the information would give rise to administrative problems and a drain on resources" (para 41), observing that such consequences are the price which has to be paid, from time to time, for freedom of expression in a democratic society.

75. The judgments of the majority in *Broadmoor,* and the endorsement of Lord Woolf MR's statement of principle by this court in *R v Rollins,* establish that a hospital authority (or other public authority) can apply to the court for an injunction to prevent conduct which interferes with its performance of its statutory functions, and that the court can grant an injunction where the circumstances make it just and convenient to do so (and, it is necessary to add, provided that the grant of an injunction is compatible with Convention rights, where those are engaged).

76. On the other hand, the judgments also make it clear that (under the legislation there in question) a hospital authority does not have the power to bring proceedings on the *Broadmoor* basis in order to protect its patients' rights to privacy or confidentiality, or to protect the rights of third parties. Such proceedings normally have to be brought by or on behalf of those individuals themselves, since it is to them that the relevant duty is owed (*Fraser v Evans* [1969] 1 QB 349, 361). The position is different where, on the facts, the hospital authority can itself assert a relevant right, such as a right of confidence in respect of its own records, as in *Ashworth Hospital Authority v MGN Ltd* [2001] 1 WLR 515 (the Court of Appeal's conclusion on this point was not challenged on the subsequent appeal to the House of Lords ([2002] UKHL 29; [2002] 1 WLR 2033). In addition, as Lord Woolf MR indicated in *Broadmoor* (para 70 above), it is possible for the hospital authority to bring a claim which has the effect of protecting its patients (or third parties) where it relies on the interference which the conduct of which complaint is made would have on the performance of its duties.

77. No reliance was placed on this line of authority in the present proceedings, and there has been no examination of the statutory powers and duties of the Trusts. In principle, however, it appears that *Broadmoor* might have provided an alternative basis to the parens patriae jurisdiction for granting injunctions which prohibited the identification of the clinicians, where their identification could have consequences which interfered with the Trusts' performance of their functions. Indeed, in *In re C,* the Master of the Rolls justified the grant of the injunction prohibiting the identification of the hospital partly on the basis that "[i]n its absence there will be a real risk that those seeking information will gather outside the hospital and interrogate all who are entering it or leaving it … This will have serious effects upon the efficient running of the hospital" (p 48). The *Broadmoor* jurisdiction can be exercised compatibly with Convention rights in this context, since the interests which can justify an interference with article 10 rights include the protection of health, among other potentially relevant matters.

78. The *Broadmoor* jurisdiction is available for as long as there is a risk of interference with the trust's performance of its functions. As we explained at para 66 above, an injunction granted on that basis can therefore extend beyond the end of the proceedings into a cooling-off period.

(c) The clinicians' cause of action in tort

79. A number of causes of action under the law of tort are relevant to the protection of clinicians from harassment and abuse. Depending on the circumstances, proceedings may, for example, be brought to prevent defamation, trespass, breach of confidence, harassment contrary to the Protection of Harassment Act 1997, infringement of the processing regime established by the General Data Protection Regulation (Regulation (EU) 2016/679) and the Data Protection Act 2018, and misuse of private information and invasion of privacy. The latter cause of action may be particularly significant. It has developed in recent times, partly at least in order to secure rights relating to privacy in English law as required by article 8 of the Convention, while also giving effect to freedom of expression in accordance with article 10.

80. That evolution began, in cases such as *Campbell v MGN Ltd* [2004] UKHL 22; [2004] 2 AC 457*,* with the development of the equitable action for breach of confidence by absorbing into it the values underlying articles 8 and 10, so as to protect private personal information. More recently, the courts have held that the invasion of a claimant's right to private and family life gives rise to a distinct cause of action in tort, variously described as misuse of private information or as invasion of privacy, based upon privacy rather than confidentiality: *ZXC v Bloomberg LP* [2022] UKSC 5; [2022] AC 1158. The approach adopted in cases concerned with the disclosure of information, as explained in *ZXC v Bloomberg LP*, has been to ask in the first place whether the information in question is private. The answer has been held generally to depend on whether it is information in respect of which the claimant had a reasonable expectation of privacy. If

the information is private, the next question is whether it has been used by the defendant in a way which constitutes an infringement of the claimant's right to privacy. That may (and usually does) involve deciding whether the interference with the claimant's privacy is justified by a competing interest, such as the defendant's right to freedom of expression. In relation to all stages of the analysis, guidance can be found in a rapidly growing body of domestic legal precedent, as well as in developments in other jurisdictions which share our common law tradition, and in the jurisprudence of the European court. The courts have also recognised that the cause of action is not limited to the disclosure of private information, but extends to other forms of invasion of privacy, in such cases as *PJS v News Group Newspapers Ltd* [2016] UKSC 26; [2016] AC 1081 and *Khuja v Times Newspapers Ltd* [2017] UKSC 49; [2019] AC 161. That cause of action may therefore provide a basis for the grant of injunctions to protect clinicians against wrongful invasions of their privacy, including injunctions which prohibit their identification.

81. The clinicians' cause of action in tort has to be asserted in a claim brought by the clinicians themselves. This may present practical difficulties in the context of a dispute over the withdrawal of life-sustaining treatment, as the clinicians may be under pressure enough in caring for the child at that critical stage without having to undertake all that is involved in the bringing of legal proceedings. However, that potential problem is capable of being overcome if the trust undertakes the necessary preparations, by agreement with the clinicians, and the clinicians' application for a quia timet injunction against disclosure of their identity, to protect their claim to protection from harassment or privacy in tort and under article 8, is joined to the proceedings brought by the trust under the parens patriae jurisdiction or the *Broadmoor* jurisdiction (or both). The clinicians' claim can then be advanced as part of the same proceedings. In practical terms, for the trust to support the bringing of the clinicians' claim in this way, and have their claim joined to its own, will normally be little more than a formality, as the trust's case for the grant of an injunction is based on the same concern as the clinicians': the apprehended risk that the clinicians involved in the child's care would be subjected to abusive behaviour in the event that they were to be identified. The evidence relied on at that stage of the proceedings in order to establish the existence of such a risk is likely to be generic, as we have explained.

82. Accordingly, the joinder of the clinicians' claim to the proceedings brought by the trust would be unlikely to put it to any significant additional trouble or expense. It would then undertake the preparation of the proceedings, assisted by its lawyers. Where appropriate, one clinician could be party to the proceedings as the representative of others, in accordance with CPR r 19.8. We would expect – although, as the matter has not been argued, we do not express any concluded view – that the clinicians' participation in the proceedings could properly be funded by the trust, on the basis that the risk which they face has only arisen in consequence of the proceedings for a declaration brought by the trust, for which they are working.

(d) The inherent equitable jurisdiction and section 6(1) of the Human Rights Act

83. As was explained in *Wolverhampton* at paras 16-22 and 145-148, the court possesses an inherent and unlimited equitable power to grant injunctions, subject to any statutory constraints. That power is confirmed and restated in section 37(1) of the Senior Courts Act. It is possible, in particular, for injunctions to be granted against non-parties, and to be granted contra mundum, as was explained in the *Wolverhampton* case at paras 23-26. However, although the equitable jurisdiction is theoretically unlimited, the court exercises the power to grant an injunction in accordance with recognised principles and with any restrictions established by judicial precedent and rules of court.

84. Counsel for the Trusts argued that the court was required by section 6(1) of the Human Rights Act to exercise its equitable jurisdiction so as to grant an injunction to protect the clinicians' rights under article 8 of the Convention, even though they were not party to the present proceedings. Section 6(1) provides:

> "It is unlawful for a public authority to act in a way which is incompatible with a Convention right."

A court is a public authority for the purposes of that provision: section 6(3)(a). The effect of section 6(1) is to make it unlawful for a court to act in a way which is incompatible with a Convention right. The court cannot properly act or conduct itself in that way: *Attorney General's Reference (No 2 of 2001)* [2003] UKHL 68; [2004] 2 AC 72, paras 30 (Lord Bingham of Cornhill) and 32 (Lord Nicholls of Birkenhead).

85. Section 6(1) does not confer any power on the court which it does not otherwise possess. Rather, it applies within the ambit of the powers which the court otherwise possesses. As Lord Nicholls observed in *In re S (Minors) (Care Order: Implementation of Care Plan)* [2002] UKHL 10; [2002] 2 AC 291, para 80, "[s]ection 6 is prohibitory, not enabling". Similarly, Lord Hope of Craighead explained in *In re British Broadcasting Corpn* [2009] UKHL 34; [2010] 1 AC 145, para 13, that section 6(1) "has an important part to play when a court is considering how it should exercise a power that has been conferred upon it by statute or, in the case of the High Court for example, is vested in it by an inherent jurisdiction", but "it cannot confer on a court a power that it does not otherwise have."

86. The court's inherent equitable jurisdiction is in principle sufficiently wide to enable it to grant an injunction when its failure to do so would be incompatible with Convention rights. That was the basis on which Lord Steyn preferred to analyse an application for a contra mundum injunction to prevent the naming of a defendant in criminal proceedings, in order to protect the private life of her child, in *In re S* at para 23, although the application had been made under the parens patriae jurisdiction. As Lord Rodger of Earlsferry observed in *In re Guardian News and Media Ltd* [2010] UKSC 1; [2010] 2 AC 697, para 30, reliance on section 6(1) of the Human Rights Act removed any

doubts that might otherwise have existed (at that time) as to the general availability of a remedy under English law to protect rights to privacy as required by article 8.

87. However, domestic causes of action are the means by which compliance with Convention rights, including those protected by article 8, is normally secured. The function of the Convention is generally to set a boundary which domestic law cannot go beyond without contravening international obligations: as Lord Mance said in *Kennedy v Information Comr* [2014] UKSC 20; [2015] AC 455, para 46, "the Convention rights represent a threshold protection". The Convention does not prescribe what the content of domestic law must be within that boundary. On the contrary, the European court allows a margin of appreciation to national authorities. Our domestic law is determinative of rights and obligations within that margin of appreciation.

88. Accordingly, in situations where the Convention has what is sometimes described as "horizontal" as contrasted with "vertical" effect – that is to say, where it requires domestic law to secure Convention rights by regulating the legal relations between private individuals or bodies, as distinct from the legal relations between private individuals and the state – domestic law normally complies with the Convention by providing an appropriate cause of action, thereby enabling parties to apply to the court for a remedy which will protect their Convention rights. As Baroness Hale of Richmond stated in *Campbell v MGN Ltd*, para 132:

> "The 1998 Act does not create any new cause of action between private persons. But if there is a relevant cause of action applicable, the court as a public authority must act compatibly with both parties' Convention rights."

89. The point can be illustrated by a familiar example of an interest which is protected by article 8 of the Convention, namely an individual's interest in his or her reputation. In English law, that interest is protected primarily by the law of defamation. Individuals who wish to prevent the publication of defamatory statements about themselves can apply for an injunction on the basis of their cause of action in defamation. They cannot properly ignore the domestic law of defamation and bring proceedings based solely on section 37(1) of the Senior Courts Act taken together with section 6(1) of the Human Rights Act. That is because our law of defamation is not constituted by article 8 of the Convention, although that provision is relevant to its application. A fortiori, if a third party, such as the individuals' employer, were to apply for an injunction in order to protect them from defamation, relying on the width of the court's powers under section 37(1) of the Senior Courts Act and on section 6(1) of the Human Rights Act, the court would not be acting unlawfully if it refused to grant a remedy in those proceedings. The court does not act in a way which is incompatible with a Convention right by insisting that individuals avail themselves of the domestic cause of action which is available to protect that right, and that the action is brought by the individual whose Convention right is in issue.

90. The position is the same in relation to many other interests protected by article 8, such as individuals' interests in preventing the publication of confidential personal information, or in protecting themselves against harassment, or in preventing intrusions into their homes. Our domestic law provides them with causes of action against persons who threaten those interests, and they must normally avail themselves of those causes of action if they wish to obtain a remedy from the courts. Third parties do not normally have standing to apply for a remedy to protect those individuals' interests, and the courts would not normally be acting unlawfully under section 6(1) of the Human Rights Act in declining to grant a remedy on a third party's application. In other words, in this context, in so far as the state is under a positive obligation arising from article 8 to intervene in relations between private persons in order to protect such interests, the obligation is usually satisfied by providing the person affected with the means of seeking legal redress.

91. Those causes of action which are available to ensure compliance with article 8 – such as defamation, trespass, breach of confidence, harassment contrary to the Protection of Harassment Act 1997, infringement of the processing regime established by the General Data Protection Regulation (Regulation (EU) 2016/679) and the Data Protection Act 2018, and, more recently, misuse of private information and invasion of privacy – are the subject of a developed or developing body of law, in which rules and principles have been established or are in the process of becoming established. Those rules and principles reflect how our domestic law balances competing interests – for example, in the law of defamation, through the concepts of absolute and qualified privilege, through the defence of truth, and through statutory provisions such as section 4 of the Defamation Act 2013. Furthermore, as Lord Sumption noted in *Khuja v Times Newspapers Ltd*, para 23, the rules and principles laid down in long-established areas of the law concerned with balancing freedom of expression and competing interests can be expected to influence those emerging in the cognate area of invasion of privacy, in so far as they are relevant. The courts do not have only the European case law on articles 8 and 10 to guide them, and it would be a serious mistake for them to attempt to decide domestic legal disputes by reference only to that case law.

92. Although articles 8 and 10 of the Convention are of unquestionable importance, their function is different, as we have explained. Inevitably, since the European court decides specific complaints that domestic authorities have exceeded what is permissible under the Convention, rather than determining the content of domestic law within those limits, its judgments have not established a body of rules or principles which is as rich or detailed as that existing or emerging in our domestic law. Rather, the judgments in cases where articles 8 and 10 are involved are based on an assessment of the facts of individual cases, drawn from a wide variety of legal contexts across the jurisdictions of the Council of Europe, and considered after the domestic proceedings have been completed. The focus of the judgments, in cases concerned with articles 8 and 10, is usually on whether the national margin of appreciation has been exceeded. It can be difficult to derive from them rules more specific than the broad statements of principle which have been repeated over decades. Accordingly, as Lord Mance said in *Kennedy v Information Comr*, para 46, "the natural starting point in any dispute is to start with domestic law, and it is certainly not to

focus exclusively on the Convention rights, without surveying the wider common law scene". That point (and others we have made about the relationship between the common law and Convention rights) is illustrated by the reasoning in *R (UNISON) v Lord Chancellor (Nos 1 and 2)* [2017] UKSC 51; [2020] AC 869, para 64 and *Fearn v Board of Trustees of the Tate Gallery* [2023] UKSC 4; [2024] AC 1, paras 113 and 206; see also *QX v Secretary of State for the Home Department* [2024] UKSC 26; [2024] 3 WLR 547, para 53.

93. Seen against that background, the reasoning of Lord Steyn in *In re S,* which based the court's jurisdiction in that case on section 6(1) of the Human Rights Act, was highly unusual (as we will explain, it also depended on a broad approach to the remedial scheme of the Human Rights Act). However, it reflected the absence from English law, at that time, of any general cause of action for the invasion of privacy: see *Campbell v MGN Ltd,* decided a few months before *In re S,* and *Wainwright v Home Office* [2003] UKHL 53; [2004] 2 AC 406, decided the previous year. Accordingly, the juridical basis of any general right to privacy (as distinct from more specific rights, such as the right in equity to protect the confidentiality of personal information) could only be found in article 8 itself, as given effect by the Human Rights Act. One might add that the novelty in *In re S* lay more in Lord Steyn's reasoning than in what the courts actually did, as the Court of Appeal reached the same conclusion as the House of Lords in the exercise of the parens patriae jurisdiction.

94. The law has moved on since *In re S.* In more recent times, the courts have been willing to develop the common law when necessary in order to meet the requirements of the Convention, and have deprecated the tendency in some earlier cases to see the law solely in terms of the Convention itself: see, for example, *R (Guardian News and Media Ltd) v City of Westminster Magistrates' Court* [2012] EWCA Civ 420; [2013] QB 618, para 88, *R (Osborn) v Parole Board* [2013] UKSC 61; [2014] AC 1115, paras 54-63, and *Kennedy v Information Comr*, para 46. In particular, the common law has evolved to provide a cause of action protecting rights relating to privacy, as we have explained at paras 79-80 above. That cause of action is available to clinicians who are threatened with wrongful invasions of their privacy.

95. Another relevant cause of action, as was pointed out in *Campbell v MGN Ltd* (para 133), arises under the inherent parens patriae jurisdiction of the High Court. As we have explained, orders may be made under the court's parens patriae powers for the protection of clinicians, where that is necessary in order to secure the rights or interests of children involved in proceedings of the present kind. In particular, such orders can provide clinicians with anonymity where there would otherwise be a risk of their suffering abuse and harassment, since such ill-treatment would be liable to have an adverse effect upon their care of the child.

96. Another relevant cause of action is the right of a public body to apply to the court for an injunction to prevent interference with its performance of its public responsibilities, established in the case of *Broadmoor*. As we have explained, it enables a hospital authority to apply for an injunction in order to protect the anonymity of clinicians or other staff who are employed by it or are otherwise providing it with their services, where their identification could have consequences which interfered with the authority's performance of its statutory duties.

97. Accordingly, there are at least three causes of action available under our domestic law under which the clinicians can be protected in the context of disputes over the withdrawal of life-sustaining treatment: their own cause of action, in particular based on the tort of invasion of privacy; the cause of action available to NHS trusts under the court's parens patriae powers; and the cause of action available to the trusts under the *Broadmoor* principle. The first of those causes of action is directly focused on the clinicians' right to privacy. It can provide a practical and effective remedy, even in the circumstances in which proceedings of the present kind are commenced, if the clinicians' claim for an injunction is joined to that of the trust, and the trust undertakes the necessary preparations. The parens patriae cause of action can also provide the clinicians with effective protection against interferences with their privacy, although it does so as a means of protecting the interests of the child rather than as an end in itself. As we have explained at para 66 above, the duration of the injunction can also be extended to cover a cooling-off period. The *Broadmoor* cause of action can also provide the clinicians with effective protection as a means of ensuring that the trust is able to fulfil its responsibilities towards its patients. Again, the injunction can extend into a cooling-off period.

98. We return, then, to the court's equitable jurisdiction to grant injunctions and section 6(1) of the Human Rights Act, in the light of this discussion of the available causes of action. Counsel for the Trusts argued that section 6(1) obliged the court to grant injunctions to protect the article 8 rights of clinicians, in proceedings at the instance of the Trusts. As we have explained, the equitable jurisdiction is in principle unlimited, subject to any statutory restrictions. Notwithstanding the general rule that parties should protect their Convention rights by availing themselves of the appropriate cause of action under our domestic law, we do not rule out the possibility that there may be circumstances in which it will be proper for the court to exercise its broader equitable jurisdiction so as to ensure that the protection afforded to Convention rights is practical and effective rather than theoretical and illusory.

99. However, in the circumstances of proceedings of the present kind, notwithstanding the undoubted pressures upon clinicians, they can normally be provided with practical and effective protection against behaviour which would infringe their article 8 rights by means of one (or a combination of more than one) of the domestic causes of action which we have discussed. Although some of those causes of action treat the protection of clinicians against the risks attendant upon publicity as the means of achieving another objective rather than as an ultimate objective in itself, they are all nevertheless concerned

to ensure that clinicians are afforded effective protection against those risks. Whatever the cause of action relied on, an appropriate balancing of interests will be necessary where defendants rely on their own rights under article 10 of the Convention; but that can be done under article 10(2) on the basis that the injunction is sought in the interests of one or more of "public safety", "the prevention of disorder or crime", "the protection of health", "the protection of the reputation or rights of others", or "preventing the disclosure of information received in confidence". Since the precise assessment involved may be affected by the rights relied on, it is preferable in principle that clinicians should assert their own cause of action in order for their interests to be fully taken into account. But in practice, the outcome of the balancing exercise at the outset of proceedings, when (to judge from the present cases) the evidence in support of an injunction is likely to be generic, can be expected in most cases to be the same whether the protection of the clinicians was sought as an end in itself or as the essential means of protecting the interests of the child or of the hospital. Where practical and effective protection can be provided by a domestic cause of action, there is no justification for reliance simply on section 37(1) of the Senior Courts Act, read together with section 6(1) of the Human Rights Act.

(e) Summary

100. It follows from the foregoing discussion that in principle, and subject to the points made below, the court has the power under its inherent jurisdiction, exercising the Crown's parens patriae powers, and in order to secure the administration of justice, to make orders such as the Abbasi and Haastrup injunctions on the application of NHS trusts at the outset of proceedings of the present kind. Such injunctions can also be supported on the *Broadmoor* basis, in so far as they are necessary in order to prevent interferences with the trusts' performance of their statutory functions. Such orders can also be granted on the application of the clinicians themselves (or a representative clinician), on the basis of their rights, notably under the tort of invasion of privacy. There is no objection in principle to the issuing of injunctions contra mundum to protect the interests of the child, or to protect the integrity of the court's process, or to prevent interferences with the trusts' performance of their statutory functions. Nor is there any objection in principle to the issuing of such injunctions against defendants against whom the claimant has no cause of action, provided that the injunction is necessary to secure the objectives referred to above.

(2) Jurisdiction after the proceedings have ended

101. As we have explained, proceedings of the present kind may end on the death of the child, if that occurs before the court has given its decision. Alternatively, the proceedings may end with a decision to grant the declaration sought, in which event the death of the child is likely to follow within a short time. A third possibility is that the proceedings may end with a decision to refuse the declaration sought, in which event the child will continue to receive life-sustaining treatment. A fourth possibility, albeit remote, is that the child may continue to live even if the declaration is granted and life-sustaining

treatment is withdrawn. Accordingly, there are in broad terms two situations in which the question of jurisdiction may arise after the proceedings have ended: first, where the child has died, and secondly, where the child continues to live. We will consider each of those situations in turn, but devote more attention to the former situation, both because it is likely to be more common, and because it was the situation which arose in the cases before us.

(a) Jurisdiction after the child has died

102. Once an injunction has been granted, the court retains jurisdiction to consider applications to discharge it or vary it. However, unless there is a proper basis on which the injunction can be allowed to continue in force, on the evidence available when the application to discharge or vary is heard, the court has no alternative but to discharge it.

103. After the child has died, the parens patriae jurisdiction to protect the interests of the child can no longer justify the continuation in force of orders such as the Abbasi and Haastrup injunctions beyond a cooling-off period as explained in para 66 above. Nor can such orders be justified at that stage as being necessary to ensure the efficacy of the court's orders in respect of the child's treatment. However, the *Broadmoor* jurisdiction can provide a justification for the continuation in force of an order restricting publicity where there remains a threat of behaviour which would interfere with the trusts' performance of their functions. Such a threat cannot be established at that stage merely on the basis of evidence concerned with events in other cases at a time when the proceedings for a declaration remained live, or where publicity had not been restricted. Nor can the *Broadmoor* principle be applied on the basis merely of concern about the potential impact of publicity on the morale of hospital staff, or on the willingness of clinicians to practise in particular areas of medicine.

104. The continuation of injunctions of the present kind after the death of the children may also be sought, as it was in the present cases, in order to protect the clinicians who treated the children from the risk of tortious behaviour such as invasions of their privacy. As we have explained, the clinicians have causes of action available to them under the law of tort which will enable them to obtain injunctions protecting their rights. The appropriate persons to seek injunctions in order to protect the rights of the clinicians are the clinicians themselves.

105. It is argued on behalf of the Trusts that section 6(1) of the Human Rights Act requires the court to continue the injunctions on the application of the Trusts in order to protect the clinicians, even though the clinicians are not themselves party to the proceedings. We are unable to accept that contention. The effect of section 6(1) is that the court cannot lawfully discharge the injunctions if to do so would be incompatible with Convention rights. No such incompatibility can arise where the clinicians have a cause of

action readily available to them at that stage, enabling them to seek the continuation of the injunctions (or the grant of fresh injunctions) in order to protect their Convention rights, but have failed to make use of it. Section 6(1) does not require the court to protect the Convention rights of individuals who are not parties to the proceedings before the court but could be parties if they chose.

106. A further difficulty with the Trusts' argument is that it is likely to be difficult in practice for the court to consider fully the clinicians' rights under article 8 of the Convention, and to decide how to balance them against the competing rights of the parents and others under article 10, in the absence of any pleaded cause of action by the clinicians, or their participation in the proceedings. Without a pleaded cause of action, supported by a body of evidence, the court may – as in the present proceedings – know little if anything about the circumstances of the individual clinicians, the nature of any apprehensions they may hold and the reasons for their being apprehensive, if indeed that is the case. Furthermore, as we will explain, it may not be possible, either under domestic law or consistently with the Convention, to treat them simply as an undifferentiated group. The court may not even know whether they wish to assert their rights, whether under the Convention or under domestic law. These issues may not loom large when an injunction is sought in circumstances of urgency at the outset of proceedings – at that stage, as we have explained, it is understandable that reliance should be placed on generic evidence – but they are of greater significance if the continuation of the injunction is in question after the declaration proceedings have ended.

107. We also note that the remedial scheme provided by the Human Rights Act, where section 6(1) is to be relied on in legal proceedings, is provided by sections 7 to 9. In particular, section 7(1) enables "[a] person who claims that a public authority has acted (or proposes to act) in a way which is made unlawful by section 6(1)" to "(a) bring proceedings against the authority … or (b) rely on the Convention right or rights concerned in any legal proceedings, but only if he is (or would be) a victim of the unlawful act". For that purpose, "a person is a victim of an unlawful act only if he would be a victim for the purposes of article 34 of the Convention if proceedings were brought in the European Court of Human Rights in respect of that act" (section 7(7)). Article 34 permits the European court to receive applications from "any person, non-governmental organisation or group of individuals".

108. Lord Steyn did not consider these provisions in *In re S,* but his reasoning treated the Human Rights Act as enabling proceedings to be brought in order to obtain orders against private parties on the basis that the court, as a public authority, would be acting in a way which was made unlawful by section 6(1) if it failed to grant the claimant the relief sought. That might be regarded as a broad interpretation of section 7(1). Nevertheless, in *In re S* and related cases, such as *In re Guardian News and Media Ltd*, the House of Lords remained faithful to Parliament's intention that claims based on section 6(1) should be brought by individuals who were (or would be) victims of the unlawful act; and it also remained faithful to the broader intention that the Human Rights

Act should enable individuals to obtain relief in domestic courts where there was or might be a breach of their rights under the Convention, rather than having to make an application to the European court. In the present proceedings, on the other hand, public authorities – which have no standing as victims in relation to the potential violation of the Convention rights relied upon – seek to use the Human Rights Act to obtain relief against private individuals, on the basis that the court's failure to grant that relief would violate the Convention rights of third parties who are strangers to the proceedings. That is not what the Human Rights Act was intended to achieve.

109. For those reasons, section 6(1) cannot have the effect of requiring the court to continue an injunction in order to protect the Convention rights of a person who, after sufficient opportunity to do so, could be a party to the proceedings but has chosen not to be. In short, where the continuation of an order against private individuals and organisations is sought for the purpose of preventing an invasion of clinicians' right to privacy, or other wrongful conduct directed against them, then that should normally be based on the clinicians' assertion of their own cause of action against those individuals and organisations.

110. It follows that, at the stage when the applications in issue before us were made to discharge the injunctions or to grant fresh injunctions, the argument for continuation of the injunctions ought not to have been presented by the Trusts on the basis of the clinicians' Convention rights, since by that stage it was the responsibility of the clinicians to present their own case for the protection of their rights, if they wished to do so. It also follows that where an injunction granted on the application of a trust has the practical effect of protecting the rights of clinicians, notice of the injunction, and of any application for its variation or discharge, should be given to the clinicians affected. They can then either join the proceedings or begin their own proceedings before the existing injunctions are discharged.

(b) Jurisdiction where the child continues to live

111. Where the child continues to live after the proceedings have ended, the court retains its parens patriae jurisdiction. However, it could only be invoked by NHS trusts in order to justify the continuation in force of orders such as the Abbasi and Haastrup injunctions, or the grant of fresh injunctions, if they were continuing to care for the child. The *Broadmoor* jurisdiction would also remain available if there remained a threat of behaviour which would interfere with the trusts' performance of their functions. If the continuation of the orders was sought on the basis of the clinicians' rights, then the appropriate parties would be the clinicians themselves, as explained above.

(3) Standing

112. The position in relation to standing follows from the foregoing discussion of jurisdiction. At the outset of the proceedings, the trust has standing, as a person caring for the child, to seek an order from the court in relation to his or her future care under the parens patriae jurisdiction. The trust also has standing to apply for an injunction under the inherent jurisdiction in order to protect the welfare of the child, or to protect the child's right to the confidentiality of his or her medical treatment, or to protect the child against an invasion of privacy, or to protect the integrity of the court's process. The trust also has standing to apply for an order under the *Broadmoor* jurisdiction in order to prevent interferences with its own performance of its statutory functions. Claims based on the rights of the clinicians should normally be brought by the clinicians themselves, although their joinder may be little more than a formality so far as the practical implications are concerned, as explained in paras 81-82 above.

113. After the proceedings have ended, the position depends on whether the child has died. If so, there is no longer any scope for the exercise of the inherent jurisdiction as parens patriae or in order to protect the integrity of the proceedings. The trust retains standing to apply for an order or to seek the continuation of an existing order on the basis of the *Broadmoor* principle, and it will be justified in doing so if there remains a risk of abuse of the clinicians and other staff in its employment, given the possible consequences for its care of other patients. If, however, the basis on which the continuation of the injunction is sought is in order to protect the rights of the clinicians, as in the present proceedings, then the parties with standing to seek the protection of their rights are the clinicians themselves. Where appropriate, one clinician can be party to the proceedings as the representative of others, in accordance with CPR r 19.8. However, the roles of clinicians, and their vulnerability to abuse, may differ even within a clinical team, especially where the publicity sought to be restrained is directed at particular individuals. Even if different clinicians have the same interest in a claim, evidence about the risk to each of them, considered separately, may be necessary.

114. If, on the other hand, the child remains alive after the proceedings have ended, then the trust will retain standing to apply to the court under the parens patriae jurisdiction provided it is continuing to care for the child. It will also have standing to invoke the *Broadmoor* jurisdiction. The parties with standing to seek the protection of the clinicians' rights will be the clinicians themselves.

(4) Open justice

115. As we have explained, the injunctions granted in the Abbasi and Haastrup cases were not made for the purpose of restricting the reporting of proceedings in court, but in order to protect the clinicians and other hospital staff involved in the children's treatment from the risk of harassment, and thereby to ensure that the treatment of the children and other patients was not disrupted. However, the injunctions also had the effect of prohibiting the identification of witnesses who gave oral evidence in the Haastrup

proceedings, or provided witness statements or reports which were adduced in evidence at the hearing. That hearing was held in private, but the parents and accredited representatives of the media were present. The names of the witnesses appear to have been disclosed at the hearing, but they were anonymised in the judgment which was subsequently published. Counsel for the parents submit that the court has no power under the inherent jurisdiction to grant an injunction having the effect of prohibiting the publication of their names.

116. This point does not appear to have been raised before Lieven J or MacDonald J at the interlocutory hearings at which the injunctions were granted: as we have explained, the orders were made without opposition, at hearings at which the media were represented. The Abbasi case did not proceed any further, as Zainab died before the date when a full hearing was to have been held. In relation to the Haastrup case, it is not suggested that any issue concerning the identification of the witnesses, or the effect of the injunction on reporting of the case, was raised with the judge.

117. Over a century ago the House of Lords recognised, in *Scott v Scott* (para 38 above), that cases concerning children are an exception to the general principle that justice is to be administered in public. As Lord Shaw of Dunfermline stated (p 483):

> "… the jurisdiction over wards and lunatics is exercised by the judges as representing His Majesty as parens patriae. The affairs are truly private affairs; the transactions are transactions truly intra familiam; and it has long been recognized that an appeal for the protection of the court in the case of such persons does not involve the consequence of placing in the light of publicity their truly domestic affairs."

118. The privacy of proceedings concerning children has also long been recognised in legislation. Currently, rule 27.10(1) of the Family Procedure Rules 2010 (SI 2010/2955) provides that family proceedings are to be held in private, subject to the court directing otherwise. There is no indication that such a direction was given in the Haastrup proceedings. Rule 27.11(2) prohibits any person from being present during any hearing other than, among others, "(b) a party to the proceedings" and "(f) duly accredited representatives of news gathering and reporting organisations". Rule 27.11(3) provides:

> "At any stage of the proceedings the court may direct that persons within paragraph (2)(f) and (ff) shall not attend the proceedings or any part of them, where satisfied that—
>
> (a) this is necessary—

(i) in the interests of any child concerned in, or connected with, the proceedings;

(ii) for the safety or protection of a party, a witness in the proceedings, or a person connected with such a party or witness; or

(iii) for the orderly conduct of the proceedings; or

(b) justice will otherwise be impeded or prejudiced."

The power conferred by rule 27.11(3) can be exercised by the court on its own initiative or pursuant to representations by, among others, a party, any witness, any children's guardian or an officer of CAFCASS. Those rules were in force at all times material to these proceedings. Accordingly, the judge could have excluded the media representatives from the hearing under rule 27.11(3), in the unlikely event that they were unwilling to respect the anonymity of the witnesses (unlikely, because the media had not opposed the grant of the injunction or sought its variation or discharge in order to enable their reports of the proceedings to include the witnesses' identities). He could have done so either on his own initiative or pursuant to representations by King's or Isaiah's CAFCASS guardian: representations which would have been highly likely, in order to protect the clinicians and Isaiah, if there had been any question of the witnesses' identities being published.

119. Against this background, the first point to be made is that it is established by *Scott v Scott* that the open justice principle had no application to the Haastrup proceedings. There is no constitutional principle that is infringed by a prohibition on the publication of the names of witnesses in proceedings held in private under the parens patriae jurisdiction.

120. We also note that section 12(1) of the Administration of Justice Act 1960 provides that the publication of information relating to proceedings before any court sitting in private shall not of itself be contempt of court except in certain specified circumstances, including "(a) where the proceedings – (i) relate to the exercise of the inherent jurisdiction of the High Court with respect to minors". As Munby J said in *Kelly v British Broadcasting Corpn* [2001] Fam 59, 72, summarising a number of earlier authorities, "in essence, what section 12 protects is the privacy and confidentiality: (i) of the documents on the court file and (ii) of what has gone on in front of the judge in his courtroom". Accordingly, it covers the names of the witnesses who gave evidence or provided statements, the identities of the experts who provided reports, and the contents of their evidence, statements and reports. It follows that, by virtue of section 12, the publication of the witnesses' and experts' names, either by the media or by the parents, would have rendered them liable to proceedings for contempt of court. That reflects the common law:

In re Martindale [1894] 3 Ch 193; *In re De Beaujeu's Application for Writ of Attachment against Cudlipp* [1949] Ch 230. For that reason also, the injunction could not be regarded as impinging upon open justice.

121. In view of the fact that a direction was given in the Abbasi case that future attended hearings were to be held in public (subject to a proviso that the court could exclude any person, other than a party, where it was in the interests of justice to do so), we should add that, even if the Abbasi case had proceeded to a public hearing, it does not necessarily follow that the injunction would have impinged unlawfully on the open justice principle. If oral evidence had been given, or statements or reports adduced, by the clinicians whose anonymity was protected by the injunction, it would have been open to the judge to exclude the public or to take the less drastic step of permitting their names to be withheld (see, for example, *Attorney General v Leveller Magazine Ltd* [1979] AC 440). If the public were excluded, the position would be the same as in the Haastrup proceedings. If the names were withheld, the court could exercise its power under section 11 of the Contempt of Court Act 1981 to give directions prohibiting their publication. In those circumstances, the injunction would not prevent the publication of anything which could otherwise have been published.

122. It is also necessary to consider the submission advanced on behalf of the parents that the court cannot lawfully derogate from the principle of open justice for the benefit of individuals who are neither parties nor witnesses in the proceedings, because to do so would be incompatible with article 6(1) of the Convention.

123. Article 6(1) provides that, in the determination of civil rights and obligations, "everyone is entitled to a fair and public hearing". However, the requirement to hold a public hearing is subject to exceptions. This is apparent from the text of article 6(1) itself, which contains the proviso that:

> "the press and public may be excluded from all or part of the trial in the interests of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so require, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice."

Furthermore, it is established in the case law of the European court that, even in a criminal law context, where there is a high expectation of publicity, it may on occasion be necessary under article 6 to limit the open and public nature of proceedings in order, for example, to protect the safety or privacy of witnesses or to promote the free exchange of

information and opinion in the pursuit of justice: see, among many other authorities, *Doorson v The Netherlands* (1996) 22 EHRR 330, para 70.

124. The submission advanced on behalf of the parents is insufficiently nuanced to reflect this approach. As the proviso to article 6(1) makes clear, exceptions to the open justice principle are capable of being justified if, among other things, they are necessary in the interests of public order, or to protect the interests of a child (as in *B and P v United Kingdom* (2002) 34 EHRR 19), or in the interests of justice. As we have explained in our discussion of *In re C* and the subsequent case law, and in our discussion of the *Broadmoor* principle, injunctions prohibiting the identification of clinical and other staff in proceedings of the present kind are in principle capable of being justified on one or more of those grounds.

6. Other aspects of the law governing the grant of injunctions in proceedings of the present kind

125. Given the different bases on which the court's jurisdiction may be invoked at different stages of proceedings of the present kind, and the different areas of law which may be relevant, it is impossible to provide comprehensive guidance. Some observations may however be made about other aspects of the law which may commonly arise.

(1) The relationship between the common law and Convention rights

126. Applications for restraints on publication usually seek protection of privacy, confidentiality or reputation, all of which are protected by the common law or equity, for example under the law of confidentiality, defamation, trespass, misuse of private information, invasion of privacy and so forth. Freedom of speech has also been afforded strong protection under the common law for centuries: see, for example, *R v Central Independent Television plc* [1994] Fam 192, 202-203. It is also protected by statute: notably by section 12(3) and (4) of the Human Rights Act. Where these interests come into conflict, our domestic law achieves a balance between them by establishing principles (such as the principles establishing defences to actions in defamation) which the court then applies to particular facts.

127. In protecting those interests, the courts are also required by section 6(1) of the Human Rights Act to act compatibly with Convention rights: in particular, with articles 8 and 10. As we have explained, the principles established in the case law under the Convention are often expressed at a higher level of generality than those of our domestic law, and their application to particular facts generally calls for a broader exercise of judgement by the court. However, it is important to bear in mind that the starting point is our domestic law. The case law interpreting the Convention is important as setting limits to what is permissible under the Human Rights Act, but it is not an exhaustive guide to

how our law should protect either privacy or freedom of expression, or should strike a balance between them.

(2) The application of the Convention

128. The proper application of the Convention requires a more structured approach than the concept of "balancing" rights might suggest. In assessing whether there has been a breach of article 10 (or, mutatis mutandis, a breach of article 8), the court begins by asking whether there was an interference prescribed by the law. The next question is whether it pursued a legitimate aim, ie an aim which can be justified with reference to one or more of the matters mentioned in article 10(2) (or article 8(2), as the case may be). The remaining question is whether the interference was necessary in a democratic society. It is at that stage that the court may be required to strike a fair balance when protecting two values guaranteed by the Convention which may come into conflict with each other: *Axel Springer AG v Germany* (2012) 55 EHRR 6*,* para 84.

129. In a series of Grand Chamber judgments, the court has identified a number of "criteria", or factors of significance, which it addresses when balancing competing rights under articles 8 and 10: see, for example, *Von Hannover v Germany (No 2)* (2012) 55 EHRR 15, paras 109-113, *Axel Springer AG v Germany,* paras 90-95, and *Couderc v France* [2016] EMLR 19, para 93. The Grand Chamber has also said on many occasions that where the national authorities have weighed up the competing rights in compliance with the criteria laid down in the court's case law, strong reasons are required if it is to substitute its view for that of the domestic courts: see *Von Hannover v Germany (No 2),* para 107, *Axel Springer AG v Germany,* para 88, and *Couderc v France,* para 92. The factors identified by the European court should be taken into account by our domestic courts, so far as relevant, when considering the balancing of competing rights under articles 8 and 10.

130. Both in applying our domestic law, and for the purposes of article 10, the treatment of children in cases of the present kind is not a purely private matter between the treating clinicians and the children or their parents (see, for example, *Bergens Tidende v Norway* (2001) 31 EHRR 16). The treatment of patients in public hospitals is a matter of legitimate public concern, and that must be especially true of conflicts between parents and clinicians in relation to the treatment of gravely ill children. There is therefore an important public interest in the freedom of the media, and of other individuals and organisations, to impart information about such matters, subject to the duties and responsibilities described above. Expressions of opinion in the course of a debate on such matters will also be afforded a special degree of protection by the Convention, as is illustrated by such cases as *Bergens Tidende v Norway* and *Annen v Germany* (Application No 3690/10) (unreported) 26 November 2015.

(3) Protecting the privacy of clinicians

131. The disclosure of personal information about an individual is not necessarily an intrusion into his or her private life, or in any event a sufficiently serious intrusion to engage the protection either of the common law or of article 8 (see, for example, *Axel Springer AG v Germany*, para 83). It is also necessary to bear in mind that the management and staff of public hospitals have the status of public figures for the purposes of the Convention case law on articles 8 and 10: see, for example, *Frisk and Jensen v Denmark* (Application No 19657/12) (unreported) 5 December 2017, para 60.

132. A person's reasonable expectations as to privacy are a significant factor under the Convention, as they are in our domestic law. In that regard, it is material that doctors voluntarily provide their patients with their name, and that doctors and nurses generally wear name badges.

(4) Differentiating between clinicians

133. The court may not be content, or properly able, to treat clinicians as a single class with rights of the same individual strength. For example, the names, photographs, professional qualifications and specialisations of senior clinicians working in hospitals in the UK are usually published on their hospitals' websites (as they are on the websites of the Newcastle Trust and King's). In addition, as we have explained, the management and staff of a public hospital have the status of public figures for the purposes of the Convention case law on articles 8 and 10. Seniority may also tell against some clinicians in the striking of a balance between competing rights: see, for an illustration concerned with a senior officer in the armed forces, *Axon v Ministry of Defence* [2016] EWHC 787 (QB); [2016] EMLR 20. Or it may have become clear that the parents or the press have an interest in naming only particular members of the clinical team, so that the remainder face no sufficient risk to need protection.

(5) The significance of changing circumstances

134. The possibility of a material change in circumstances is a factor which should be taken into account when considering the duration of injunctions restraining publication. This point was explained in *Scott v Scott* by Lord Shaw of Dunfermline (p 483), and was summarised by Geoffrey Lane LJ in *In re F (orse A) (A Minor) (Publication of Information)* [1977] Fam 58, 107:

> "The embargo on publication of matters disclosed in a private hearing is not necessarily perpetual. Silence should only be

> enforced for so long as is necessary to protect the interests of those for whose benefit the rule is made."

A further illustration, in a statutory context, is section 4(2) of the Contempt of Court Act 1981, under which the court can order the postponement of the publication of any report of proceedings, where necessary to avoid a risk to the administration of justice, "for such period as the court thinks necessary for that purpose".

135. The same point also arises under the Convention. For example, in *Editions Plon v France* (2006) 42 EHRR 36 the European court considered interim and final injunctions separately, observing that "the need to interfere with freedom of expression may be present initially yet subsequently cease to exist": para 45. In concluding that the interim injunction was compatible with article 10, the court emphasised that the French Court of Appeal, in upholding the interim injunction, had placed a reasonable time limit upon it: para 47. On the other hand, the permanent injunction was held to be unjustified in view of the consequences of the passage of time: para 53.

136. In our view the exigencies and passage of time play an important and thus far insufficiently appreciated part in both the jurisdiction to grant injunctions restraining publicity in proceedings of the present kind, and the exercise of the discretion whether to grant, vary or discharge them. Four stages in the passage of time need to be separately considered. They are: (1) the time of the institution of the proceedings; (2) the time between then and the end of the proceedings, generally when the court decides whether to grant the declaration sought (or, if earlier, when the child dies); (3) a specified cooling-off period immediately after the end of the proceedings; and (4) the potentially limitless period thereafter.

137. At the first stage, as already noted, it is generally the trust which concludes that proceedings have become necessary. At that stage it may often be a matter of conjecture whether there will be any adverse consequences caused by publicity. The risk may not however be completely impossible to gauge, because the trust is likely to know by then whether, for example, there is developing an acute difference of view between parents and clinicians as to the child's best interests, and whether the case has attracted public attention. By comparison with a professional difference or uncertainty about the treatment which will be in the best interests of the child, the parents versus clinicians type of dispute is far more likely to lead to the abusive results of publicity.

138. This perception may provide the trust with a specific evidential basis on which to assist the court in estimating the risks attendant upon publicity. There may also have already been some publicity, as there was in relation to Isaiah's case before King's sought an injunction; and the reaction to that publicity will also be material. Commonly, however, the fact that the risk lies entirely in the future may mean that the trust will have

to rely upon generic evidence, based upon the adverse effects of publicity in earlier comparable cases.

139. The primary focus of both the trust and the parents at this stage is bound to be on the preparation of evidence directed to the best interests of the child. The obtaining of an injunction is likely to be a secondary issue, and the preparation of the application is likely to be urgent. Such focus as is given to the obtaining of an injunction is likely to be directed at the second stage, ie the period during which the proceedings are live, while the child continues to live in a state of grave illness and possibly pain and distress. For that period the protection of an injunction is likely to be in the best interests of the child, both to protect the child's right to confidentiality and privacy, and to limit as far as possible the risk of collateral damage to the continued care being provided by the hospital to the child. For both those purposes the natural applicant is the trust. The child is in its intensive care and the efficient conduct of its healthcare functions is its direct responsibility.

140. For those protective purposes the court has available its inherent jurisdiction to protect the interests of the child. As we have explained, that jurisdiction enables the court to prohibit the publication of information about the child's carers, if that is necessary in order to protect the child's interests. The court can also grant such an injunction under its jurisdiction to ensure the effectiveness of its orders in respect of the child's treatment, if the injunction is needed to prevent interferences with the ability of the carers to care for the child. The court also has available its inherent equitable jurisdiction to prevent unlawful interferences with the trust's performance of its statutory functions, as exemplified by *Broadmoor.* In each of those ways, the court can also provide effective protection of the rights of the clinicians: that is the means by which the objectives of the orders are achieved. If the clinicians (or a representative clinician) are joined to the proceedings, then the court can also grant an injunction with the specific objective of protecting their rights.

141. At that second stage the question whether to grant an injunction requires the court to consider whether to do so (or to fail to do so) would be incompatible with the Convention rights which have been properly raised before it. Those are likely to include the article 8 rights of the child (and of the clinicians, if they have been joined to the proceedings) and the article 10 rights of the parents, the media and the general public. Both article 8 and article 10 guarantee qualified rights with built-in derogations, enabling the proportionality analysis required under the Convention to be carried out. The legal framework establishing the court's jurisdiction and the relevant causes of action, as described above, means that any proportionate restrictions upon those article 10 rights which are embedded in the order will be prescribed by law, within the meaning of article 10 (and the same applies, mutatis mutandis, in relation to article 8).

142. The primary focus of both the trust as applicant and of the court itself, in fashioning an appropriate order at the outset of the proceedings, will be upon its likely effect in

managing the risks which might result from publicity during the second stage, ie while the proceedings remain live. As we have explained, during that stage the proportionality balance is likely (at least where the proceedings are brought to resolve a clinicians versus parents dispute) to come down in favour of the grant of some kind of injunction, but only for that stage. Thus an order is likely to need to be time-limited, either so as to expire automatically at the end of the proceedings or, as we suggested at para 66 above, so as to expire at the end of a chosen cooling-off period thereafter; subject, in either case, to further application. Thus, in *In re M (Declaration of Death of Child)* [2020] EWCA Civ 164; [2020] 4 WLR 52 the injunction was limited by consent to a period of 28 days after the removal of ventilatory support, subject to further application. This cooling-off period is the third of the stages listed above.

143. Although the end of the proceedings may often be more or less contemporaneous with the child's death, which brings the parens patriae jurisdiction to an end, the injunction need not necessarily come to an immediate end at that point; and there are practical reasons why it may often be desirable that it should not. It would be unfortunate, to say the least, in cases where the parents and the trust are in disagreement, if the law required their lawyers to be on standby during the child's final hours, ready to file applications as soon as death occurred. Nor should the clinicians be distracted from their responsibilities at that time by the need to initiate legal proceedings for their own protection (if they are not already party to the proceedings). The availability of grounds for maintaining the injunction in place for a time (including the *Broadmoor* jurisdiction), and the breadth of the court's equitable discretion in framing injunctions, allow it to avoid that problem. The extension of an injunction granted at the outset of proceedings into a cooling-off period will allow time for the trust to assess whether a longer continuation of the injunction is necessary. It will also allow time for clinicians (and perhaps others within the trust's staff) to prepare for obtaining longer-term anonymity, in the specific protection of their own rights to privacy, in cases where they perceive it to be necessary. They should have a reasonable time to consider their own legal position once the pressure of dealing with the clinical needs of the child has passed.

144. At the same time, the risk attendant upon publicity which names the hospital or the clinicians, where anonymity has been preserved during the life of the child and throughout the proceedings, can generally be expected to be of a lower order after the proceedings have ended, and is likely to decline relatively quickly over time. The interest of the media and the public in a case where a decision about a child's life or death remains to be taken, and where there is still some chance of preserving the child's life, is almost bound to be greater than in an essentially historical case about a child who has died (or in a case where the proceedings have ended in a decision that the child should continue to receive life-sustaining treatment). By contrast the importance of the rights of the parents to freedom of expression is unlikely to suffer a comparable decline. They are likely to want to speak out about their side of an argument about the treatment of their child for the rest of their lives.

145. It follows that, when the court is asked at the outset of the proceedings to grant an injunction which extends beyond the end of the proceedings, the inherent instability of the proportionality balance over time will need to be taken into account by the court when it decides whether to extend the order into a cooling-off period and, if so, for how long. For that purpose the court may at the outset have some information relevant to the risks of harm from publicity during the cooling-off period, for example from evidence as to the nature of the dispute (if any) which the court is being asked to resolve by the bringing of the proceedings.

146. At the stage beyond the end of a cooling-off period (ie the fourth stage in our summary above), it is possible that the clinicians may have a continuing interest in preserving their anonymity, even if there has ceased to be a serious risk of interference with the trust's fulfilment of its public responsibilities. The trust will no longer be an appropriate applicant, unless there remains a real risk of interference with its performance of its statutory functions. The clinicians themselves should receive notice of any application for the discharge of the injunction so as to enable them (or, where appropriate, a representative on their behalf) to make their own application for a fresh injunction, either in the existing proceedings or in new proceedings, if they consider that to be necessary.

147. At this fourth stage, a number of factors need to be borne in mind. The first is that the original scenario, in which the protection of the clinical team's rights to privacy could be achieved as an ancillary consequence of an injunction whose purpose was to protect the child and the caring work of the hospital, is likely to have passed. Instead, the continuation of anonymity after the end of the cooling-off period in order to protect the privacy of clinicians requires, under the Convention, a balancing exercise between the article 8 rights of a specific group of clinicians and the article 10 rights of those whom the injunction would restrain.

148. Secondly, the urgency which attended the launch of the original proceedings, and the need for all concerned to concentrate upon the issues affecting the child's best interests, has also passed. There is no similar reason why the clinicians who seek protection should not take time to set out the evidence specific to them which establishes why a relaxation of their anonymity should cause a disproportionate invasion of their rights to privacy, nor why those who wish to speak out and name names should not also be able to condescend to the detail necessary to enable the court to carry out its task reliably.

149. Thirdly, the clinicians will need to be able to explain to the court why, after the end of any cooling-off period appropriate for the protection of the hospital's work, they need protection for a significantly longer period, or even indefinitely. At that stage, the conclusion of the proceedings is likely to have reduced the weight of the case for

anonymity to one which is much more likely to be matched or outweighed by the rights to freedom of expression of those wishing to speak out.

150. For the reasons already given, it is in our view no answer to these factors to say that the court has its own duty as a public body to respect the Convention rights of the clinical team, in the absence of their joinder (individually or through a representative) as applicants for the protection of their article 8 rights. It is wrong that at that stage the parents should have to take all the burden and risk of defending their article 10 rights against the opposition of a state-funded health service, where that opposition is being deployed to protect the equally private rights of the clinicians.

151. By contrast, provided that the clinicians seeking continued anonymity are joined (individually or by an appropriate representative), there will be no difficulty about the court's jurisdiction either to discharge or continue the injunction, in the same or different terms. The court retains its broad equitable jurisdiction to grant an injunction aimed at minimising the risk of unlawful harassment or invasions of privacy (or the commission of other wrongful behaviour), and may in principle do so by restraining innocent persons, such as the parents or the media, if that is the only way of ensuring that unidentified members of the public do not use publicity as the basis for harassment thereafter. And its status as a public authority for the purposes of section 6(1) of the Human Rights Act will be sufficient for it to conduct a balancing exercise between competing article 8 and article 10 rights, applying the criteria identified in the case law of the European court, for the purpose of ensuring that its decision either to discharge or to continue the injunction is compatible with those rights.

7. The present proceedings

152. As we have explained, the injunctions in the present proceedings were granted without opposition, after notice had been given to the Press Association. We have no reason to doubt that the court was right to make the orders. However, three aspects of the injunctions did not conform to what, in the light of the foregoing discussion, we would regard as best practice: first, the fact that they were of indefinite duration (although the Abbasi injunction made provision for a review at the final hearing, which never occurred); secondly, in the case of the Haastrup injunction, the fact that it contained no specification of the persons whose identification was prohibited; and thirdly, the fact that no provision was made for the notification of the clinicians either of the grant of the injunctions or of any subsequent application for their discharge.

153. Turning to consider the applications for discharge and the cross-applications for the grant of new injunctions, the first aspect of the hearing before the President which we should note, in the light of the foregoing discussion, is that the only parties before the court were the parents and the Trusts, together with PA Media (formerly the Press

Association) as an intervener. No clinicians or other hospital staff took part. There is no indication that they had received notice of the applications. The President recorded that the Trusts did not rely on the court's inherent jurisdiction with respect to the welfare of the children (who had, of course, died), nor on any other aspect of the inherent jurisdiction, nor on the tort of misuse of private information. Nor was any reliance placed on the *Broadmoor* principle. The court's jurisdiction to continue the injunctions or to grant fresh injunctions was said to derive from the existence of the applications. Given their existence, the court was (it was argued) under a duty to deal with them in accordance with section 6(1) of the Human Rights Act by carrying out a balancing exercise between the rights of the clinicians under article 8 and those of the parents and others under article 10. The President accepted that submission and proceeded on that basis.

154. We accept that the court had jurisdiction to determine the applications for discharge and to consider the cross-applications for fresh injunctions; but it could not properly continue the injunctions, or grant the cross-applications, unless there was a legal basis on which it could appropriately do so, put forward by a party with the necessary standing. Section 6(1) of the Human Rights Act did not in itself provide such a basis, for the reasons explained earlier. Nor did the Trusts have standing to assert the clinicians' rights either under the common law or under the Convention, as explained above. If the court was to be asked to continue or grant injunctions in order to protect the clinicians' rights, at a stage when the parens patriae jurisdiction was no longer available and no reliance was placed on the *Broadmoor* jurisdiction, there should have been an application by the clinicians themselves, who should have received notice of the Trusts' and the parents' applications.

155. Another notable aspect of the hearing before the President is that he was not provided with any evidence of a risk to the clinicians' rights which concerned the specific cases before him. Instead, the evidence was concerned with the harassment of hospital staff in other cases – particularly those of Charlie Gard and Alfie Evans. It was understandable that reliance should have been placed on generic evidence at the outset of the proceedings, but much less so after a number of years had passed and there was experience of the results of publicity in the particular cases before the court (see paras 12, 15, 18 and 33-34 above). Furthermore, the evidence relating to the Gard and Evans cases concerned events which had occurred at a time when the proceedings remained active. That evidence was of limited assistance in assessing the risks involved in the Abbasi and Haastrup proceedings long after the children had died. However, neither the submissions nor the President's reasoning appear to have grasped the importance of the lapse of time that had occurred in the present cases.

156. There are a number of other matters that we should mention. First, the President accepted a submission that the requirements set out in article 10(2) of the Convention "do not apply to a horizontal dispute between individuals, or groups of individuals, such as the present" (para 85). Accordingly, "reference to the matters set out in article 10(2) are (sic) not required in a horizontal dispute such as the present" (para 113). With respect,

that is not correct. Where it is sought to impose a restriction on freedom of expression, the restriction must be justifiable under article 10(2). It must be prescribed by law, it must pursue a legitimate aim, referable to one or more of the matters set out in article 10(2) (i.e. "in the interests of national security, territorial integrity or public safety, for the prevention of disorder or crime, for the protection of health or morals, for the protection of the reputation or rights of others, for preventing the disclosure of information received in confidence, or for maintaining the authority and impartiality of the judiciary"), and it must be necessary in a democratic society. A restriction which was not justifiable under article 10(2) would be incompatible with the Convention rights of the person restrained. That would be so whether the restriction was imposed in proceedings brought by a public authority (as, in fact, the proceedings before the President were), or in proceedings brought by a private individual.

157. Secondly, in the course of his judgment, the President considered Munby LJ's observation in *A v Ward* [2010] EWHC 16 (Fam); [2010] 1 FLR 1497, para 180, that "in an increasing clamorous and decreasingly deferential society there are many people in many different professions who, however much they might wish it were otherwise, and however much one may deplore the fact, have to put up with the harassment and vilification with which the internet in particular and the other media to a lesser extent are awash". The President said that he would dissociate himself from that passage, and asked rhetorically why the law should support a situation in which conscientious and caring professionals are at risk of harassment and vilification simply for doing their job (para 96). We agree. The fact that the internet is awash with harassment and vilification is no reason why anyone should be expected to put up with it, if it reaches a level which constitutes an interference with their legal rights.

158. Thirdly, the President took issue with another passage in Munby LJ's judgment in *A v Ward* where he said, in relation to a claim that clinicians and social workers should, as a class, have their identity concealed from the public, that it was "a bold and sweeping claim, to be justified only by evidence and arguments more compelling than anything which Mr Lock or his clients have been able to put before me" (para 181). The President considered that Munby LJ's conclusion (as he interpreted it) that "compelling" reasons were required was at odds with Lord Steyn's statement in *In re S,* para 17, in relation to articles 8 and 10 of the Convention, that "neither article has *as such* precedence over the other" (emphasis in the original). In the President's view, to require compelling reasons would automatically afford precedence to article 10 (para 94). In accordance with *In re S,* there should in his view be no requirement for "compelling reasons" (para 95).

159. We respectfully disagree with those comments. It is firmly established in the case law of the European court that "the need for any restrictions [of freedom of expression] must be established convincingly": *Axel Springer AG v Germany*, para 78. The Grand Chamber has also said that "a journalist cannot in principle be required to defer publishing information on a subject of general interest without compelling reasons relating to the public interest or protection of the rights of others": *Stoll v Switzerland* (2008) 47 EHRR

59, para 131. That follows from the fact that, as the Grand Chamber said in *Morice v France* (2016) 62 EHRR 1, para 125, "there is little scope under article 10(2) of the Convention for restrictions … on debate on matters of public interest". Those dicta were in point in the circumstances of *A v Ward.* We do not understand Munby LJ to have meant any more than that more convincing reasons were required, to justify the restriction on freedom of expression that was sought, than had been placed before him. Indeed, this court has also referred to the need for "compelling" submissions or "compelling" evidence to justify restrictions of freedom of expression: see, for example, *In re Guardian News and Media Ltd,* paras 17 and 74, in relation to anonymity orders designed to protect article 8 rights, and *In re Abortion Services (Safe Access Zones) (Northern Ireland) Bill* [2022] UKSC 32; [2023] AC 505, paras 117 and 137, in relation to restrictions on rights of protest intended to protect article 8 rights.

160. The need for restrictions of freedom of expression to be established convincingly reflects the fact that freedom of expression is, as the European court said in *Axel Springer AG v Germany*, "one of the essential foundations of a democratic society and one of the basic conditions for its progress and for each individual's self-fulfilment" (para 78). That does not in any way imply that the interests protected by article 10 have, as such, precedence over the interests protected by article 8. Clearly, there are many situations in which restrictions on freedom of expression are justified in order to protect the rights of others (including rights protected by article 8), as article 10(2) itself recognises. Furthermore, the weight to be attached to freedom of expression, and to privacy, will plainly depend on the circumstances of the particular case.

161. The fourth matter which we should mention in relation to the President's judgment is his emphasis on the absence of any fact-finding process to determine whether the parents' concerns were well-founded, and on the lack of specificity as to the allegations which they wished to make. Without such detail, the President stated, the court had no means of evaluating what public interest, if any, there might be in what was to be said (para 103).

162. We accept that the points made by the President can in principle diminish the weight of the article 10 rights in the balancing exercise. However, we are unable to agree with his comment as to a lack of specificity on the facts of the Abbasi case, as Zainab's father made detailed criticisms of his daughter's care, as well as of the clinicians' behaviour towards him and his wife. They included: (1) the allegedly inappropriate attitude on the part of clinicians in the form of a reluctance to treat Zainab's respiratory disorders because of her underlying neurodegenerative condition; (2) the decision to move Zainab to palliative care, and in particular the discussion at a management meeting on 19 August 2019 (which he recorded), at which he feels that he and his wife were pressurised by clinicians; (3) the circumstances of his arrest on the same date (which were recorded on video by police body-worn cameras); (4) the alleged refusal of Zainab's treating physician to meet a senior paediatric respiratory consultant from the Royal Brompton Hospital who provided an opinion, following an assessment of Zainab on 8

September 2019, that she could be treated, in a time-limited way, with a further high dose of steroids; and (5) alleged inaccuracies or lies on the part of those clinicians who gave evidence in an emergency telephone hearing on 15 September 2019. Dr Abbasi has explained that his motivation for ventilating these matters is not personal vilification, but to achieve an improvement in systems and procedures, and to prevent a repetition of what he sees as the failures of the Newcastle Trust and its staff. He wishes to stimulate a public debate.

163. Mr Haastrup has also identified the areas of public, as well as private, concern about which he wishes to speak. These include: (1) the negligence of King's staff during Isaiah's birth; (2) the alleged financial motivation for taking the end-of-life route, in the context of the Trust's liability in damages for medical negligence; and (3) the circumstances surrounding Isaiah's last day of life.

164. In relation to the President's emphasis on the absence of any fact-finding process, we note that the recordings of the Abbasi parents' meeting with clinicians and of Dr Rashid Abbasi's arrest were produced in evidence. The President was in a position to consider whether the parents' complaints in relation to those matters could be rejected as totally without substance or merit, and therefore of no weight in the article 10 assessment. Dr Abbasi's criticisms of Zainab's treatment were based on his and his wife's medical expertise and experience, including his expertise and experience as a consultant respiratory physician. As regards the Haastrup case, the negligence of King's staff during Isaiah's birth was admitted. We would also observe that, where restrictions are sought to be imposed on freedom of expression, especially in advance of publication, there will often be no likelihood of a fact-finding process; but that is not in itself a reason for imposing restrictions.

165. Turning next to the judgment of the Court of Appeal, we respectfully agree with the court's conclusion that the High Court had inherent jurisdiction to grant the injunctions at the outset of the proceedings under its parens patriae powers, and could also make such orders as it considered necessary to protect the integrity of the proceedings themselves. We also agree with the court's conclusion that the High Court necessarily had jurisdiction to consider applications to discharge the injunctions which it had granted. The Court of Appeal proceeded directly from that conclusion to a consideration of how to balance the article 8 rights of the clinicians and the article 10 rights of the parents and others on the facts of the case, seemingly on the basis that section 6(1) of the Human Rights Act required it to do so.

166. We do not agree with that approach in the circumstances of these proceedings. We accept that the court's powers are wide enough in principle to enable it to grant and continue injunctions in order to protect Convention rights even in the absence of any claim by the persons whose rights are in question. As we have explained, however, such a step would only be justified in unusual circumstances. Where the persons whose rights

are sought to be protected could readily bring a claim themselves, there is no obligation on the court under section 6(1) of the Human Rights Act to issue or continue an injunction on the application of a third party.

167. In its consideration of the arguments concerning articles 8 and 10 of the Convention, the Court of Appeal drew an analogy between assessing the significance of a risk of an interference with article 8 rights resulting from an exercise of freedom of expression, on the one hand, and assessing the significance of a risk of a violation of article 3 resulting from deportation or extradition. We do not see any relevant similarity between the two situations.

168. The Court of Appeal rightly noted the high value attached to freedom of expression both under the common law and under article 10 of the Convention: a value which, as the Court of Appeal observed, is reflected in the use of adjectives such as "convincing" and "compelling" by both the European court and domestic courts to describe the nature of the considerations required to justify restrictions. At the same time, as the Court of Appeal correctly noted, there is no hierarchical primacy as between article 8 and article 10.

169. In relation to the merits of the applications, the Court of Appeal began by considering the article 8 rights of the clinicians. As they noted, the continuation of the injunctions was sought because of a risk that the exercise of free speech by the parents or the press might result in a social media reaction by third parties. The concern was not about what the parents might say, or about reporting in the mainstream media: the concern was about the possibility that a furore might develop on social media, with consequences for the clinicians' safety and wellbeing.

170. In assessing that possibility, the first point to note, in relation to the Abbasi proceedings, is that the identity of the Newcastle Trust had ceased to be protected by the injunction on Zainab's death, in September 2019; and the identity of the hospital where Zainab was treated had ceased to be protected in July 2020 (see paras 12, 24 and 25 above). That variation of the injunction was followed by widespread media coverage of the case (paras 12 and 33 above). As we have explained, once the hospital was known, the senior paediatric clinicians who worked there could be identified from the Trust's website; and anyone versed in searching the internet might be able to discover further personal details, such as addresses and telephone numbers. Yet there was no evidence that the disclosure of the identity of the Trust or of the hospital resulted in any adverse consequences for any clinicians or for the hospital itself by the time of the hearing before the Court of Appeal in mid-November 2022.

171. The position was similar in the Haastrup proceedings. The case was the subject of media coverage from August 2017, when the proceedings began, until September 2020, following the inquest (paras 15 and 18 above). Much of the coverage was in national

media. There was also comment on social media. The identity of the hospital where Isaiah was treated was known at all times. Yet there was no evidence that any problems resulted, either for the hospital or for its clinicians.

172. In those circumstances, the Court of Appeal concluded that, whatever the position might have been at the time when the injunctions were originally granted, the current risk to the article 8 rights of the four clinicians in the Abbasi case, and of the NHS staff generally in the Haastrup case, by reason of their being identified by the parents and then by the press, was low. By contrast, the impact of the continuation of the injunctions on the article 10 rights of the parents was unquestionable and serious. In both cases, the parents wished to publish details of their experiences and concerns in an area of public controversy. The moral and ethical questions surrounding the treatment of children and adults in positions analogous to Zainab and Isaiah generate intense public debate. Naming the clinicians involved is relevant to that debate. The Court of Appeal referred to the well-known passage in the judgment of Lord Rodger in *In re Guardian News and Media Ltd*, para 63, explaining why in media reporting on a matter of public interest it may be editorially important to name individuals:

> "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."

Furthermore, in the Haastrup case there could be no justification at that stage for continuing to prohibit Isaiah's parents from talking about the circumstances of his birth, including his mother's treatment. Those involved in clinical negligence resulting in death would need a factually quite exceptional case to secure anonymity. Accordingly, taking account only of the Convention rights of the clinicians, and balancing them against the parents' rights to freedom of expression, the parents' rights decisively prevailed.

173. That reasoning left out of account the systemic concerns expressed by the interveners in the Court of Appeal: put shortly, that unless clinical staff involved in proceedings of the present kind are granted indefinite anonymity, morale will be undermined and it may become difficult to attract clinical and nursing staff to work in the relevant specialties. As the Court of Appeal noted, these concerns do not relate to the particular facts of these cases or to the circumstances of any individual. The argument, if accepted in the form in which it is put, would support permanent injunctions to protect medical and nursing staff as a class in every such case, creating a general category of restrictions on freedom of speech.

174. The Court of Appeal considered that these matters did not fall to be weighed in the balance when considering the article 8 rights of the hospital staff. The court also

considered whether they should be taken into account under article 10(2), and concluded that there was no case law of the European court which had come close to allowing such concerns to provide a justification for restricting freedom of expression. In any event, the Court of Appeal considered that these concerns were not capable of justifying an interference with the parents' article 10 rights.

175. In relation to this issue, there is a body of case law of the European court concerning the justification under article 10 of restrictions on freedom to criticise a variety of public servants, including judges, civil servants and, more recently, the medical and management staff of public hospitals. The Grand Chamber has accepted that the judiciary must enjoy public confidence if it is to perform its role in a democratic society. Nevertheless, it has held that, "save in the case of gravely damaging attacks that are essentially unfounded", judges "may … be subject to personal criticism within the permissible limits, and not only in a theoretical and general manner". Indeed, since they form part of a fundamental institution of the state, they "may be subject to wider limits of acceptable criticism than ordinary citizens": *Morice v France,* para 131. Whether a restriction of freedom of expression is justified, in relation to derogatory remarks about judges, therefore depends on the circumstances of the individual case, without any general principle or presumption that restrictions are justified.

176. In much the same way, the court has accepted in several cases concerned with civil servants, public prosecutors and law enforcement officers that it may be necessary to protect them from offensive, abusive and defamatory attacks which are calculated to affect them in the performance of their duties and to damage public confidence in them and the office they hold; but it has also made it clear that public servants acting in an official capacity may be subject to wider limits of acceptable criticism than ordinary citizens, and that the requirements of protecting them have to be weighed against the interests of freedom of the press or of open discussion of matters of public concern: see, for example, *Mamere v France* (2009) 49 EHRR 39, para 27. Again, it is necessary to examine the circumstances of the individual case in order to decide whether a particular restriction is justified.

177. More recently, in *Frisk and Jensen v Denmark* the court considered a complaint that article 10 had been violated by the conviction and fining of journalists under the Danish penal code for defaming a public hospital and one of its consultants. The journalists were responsible for a television programme which had accused the hospital and the consultant in question of malpractice in the treatment of patients. The European court treated the attack on the hospital as an attack on the reputation of its management and staff, and accepted that the applicants' conviction and punishment were aimed at protecting the "reputation of others" and had a legitimate aim under article 10(2). However, the court also accepted that the programme in question dealt with issues of legitimate public interest. The criticism was directed at a public hospital, including its management and staff. They were public figures, vested with official functions, and the limits of acceptable criticism were wider than in the case of private individuals. As the

court noted (para 60), it was accepted that there was a need for wider limits for public scrutiny because the activities of the hospital and its conditions had an impact on the life and health of individuals. The court also cited with apparent approval the Danish court's statement that "in respect of public hospital treatment, when balancing considerations of freedom of expression with considerations of the protection of the name and reputation of persons and companies, the former is accorded tremendous weight on the scale" (ibid). The court proceeded to apply its usual criteria when balancing the right to freedom of expression against the right to respect for private life, and concluded that there had been no violation of article 10, primarily because the accusations made in the programme were unfounded in fact.

178. In the light of this body of case law, we conclude that the protection of clinicians and other staff working in public hospitals from unfounded accusations is a legitimate aim. It is reasonable to infer that analogous reasoning could also apply to the protection of such persons from other forms of intrusion upon their article 8 rights. The importance of that legitimate aim could be relevant to the justification of a restriction on freedom of expression, whether considered under article 8 (in determining the weight under article 8(2) of "the rights and freedoms of others") or under article 10 (in determining the weight under article 10(2) of "the reputation or rights of others"). We do not, therefore, agree with the Court of Appeal that considerations of that kind cannot by their nature be relevant to the article 8 rights of hospital staff. However, it is also clear from the case law that, although the protection of clinicians and other staff working in public hospitals can be a legitimate aim of a restriction on freedom of expression, such a restriction will only be compatible with article 10 if it meets some important requirements, including that it does not impose a disproportionate restriction on debate on matters of general public interest, and that it does not prevent responsible criticism, including personal criticism, in cases of legitimate concern.

179. It follows that to grant permanent anonymity to all hospital staff involved in cases of the present kind as the first to fifth interveners suggest, regardless of the circumstances of the individual case, would not be compatible with the Convention. That does not, however, imply that the concerns expressed about the potential impact of attacks on clinicians and other hospital staff on morale and recruitment are irrelevant. Account can be taken of the importance of protecting the medical and other staff of public hospitals against unfounded accusations and consequent abuse. However, the court should also bear in mind that the treatment of patients in public hospitals is a matter of legitimate public interest, and that the medical and other staff of public hospitals are public figures for the purposes of the Convention, with the consequence that the limits of acceptable criticism are wider than in the case of private individuals.

180. Applying that approach in the present proceedings, it is necessary to focus on the facts. As explained above, it is reasonable to conclude that the risk of a social media storm had greatly diminished by the time of the hearings before the President and the Court of Appeal, and is now lower still. Given that conclusion, the matters raised by the first to

fifth interveners – which concern the consequences of a social media storm – do not now add significant weight to the arguments for continuing the injunctions.

181. As we have explained, the only basis on which the continuation of the injunctions was sought was to protect the rights of clinicians; but those rights were not being asserted by the clinicians themselves. If, on the other hand, there had been an application by the clinicians for the continuation of the injunctions in order to protect them from an invasion of privacy (or some other form of wrongful conduct), then the court would have had to consider whether the evidence demonstrated a real risk of such wrongful conduct. The evidence before the courts below did not demonstrate such a risk, as we have explained. If, however, the evidence had demonstrated such a risk, then the court would have had to consider whether the interference with the right to freedom of expression resulting from the continuation of the injunction was prescribed by law (clearly, it would have been on the hypothesis we are contemplating, as the clinicians' application would have been based on the law of tort, or equity, or statute, as the case might be); whether it pursued a legitimate aim (clearly, it would have done, on that hypothesis); and whether it was necessary in a democratic society and struck a fair balance between the competing values, bearing in mind that "the need for any restrictions must be established convincingly" (see para 159 above). Given that the parents' publication of their concerns would contribute to a debate of general interest, and given also that the hospital staff concerned were, for the purposes of article 10, public figures vested with official functions, and that the limits of acceptable criticism were accordingly wider than in the case of private individuals, it appears to us that it would be difficult to justify the continuation of the injunctions in the absence of evidence demonstrating a real and continuing threat of a serious nature.

8. Conclusions

182. For the reasons given above we would dismiss this appeal. Those reasons differ significantly from those given by the Court of Appeal, but we consider that the orders which they made were correct. There follows a short summary of our principal conclusions:

> (1) The High Court has jurisdiction, in proceedings concerned with the withdrawal of life-sustaining treatment of children, to grant injunctions protecting the identities of clinicians and other hospital staff involved in that treatment, where and for so long as that is necessary to protect the interests of those children. That jurisdiction arises under the court's inherent parens patriae powers, and under its inherent jurisdiction to protect the administration of justice. Such injunctions can be granted against parties who will not themselves act wrongfully, where that is necessary in order to protect the children's interests or the administration of justice, and they can be granted contra mundum.

(2) The High Court also has jurisdiction to issue such injunctions where that is necessary in order to prevent interference with hospital trusts' performance of their statutory functions, as explained in *Broadmoor.*

(3) The High Court also has jurisdiction to issue such injunctions where that is necessary in order to protect the rights of clinicians and other hospital staff, in proceedings brought or continued by those individuals in reliance on their rights. In principle, such proceedings can (in an appropriate case) be brought in a representative capacity.

(4) These grounds of jurisdiction are not mutually exclusive. In particular, the need to protect the interests of the children, to secure the administration of justice, and to prevent interference with the trusts' performance of their functions are likely to co-exist and to be mutually reinforcing.

(5) Such injunctions are not incompatible with the open justice principle where, as in the Haastrup proceedings, the application is made under the parens patriae jurisdiction and the substantive hearing is held in private. It is also possible to avoid any incompatibility with the open justice principle where the hearing is held in public, as was intended in the Abbasi proceedings.

(6) Applications for such injunctions should be based on the relevant cause of action under domestic law (such as the parens patriae jurisdiction, or the *Broadmoor* principle, or the rights of the clinicians under the law of tort), rather than simply on section 6(1) of the Human Rights Act and section 37(1) of the Senior Courts Act.

(7) In principle, the powers of the High Court under the latter provisions are wide enough to enable it to issue injunctions to protect the Convention rights of clinicians and other hospital staff in proceedings brought by hospital trusts, if that is the only way in which those rights can receive practical and effective protection. However, those circumstances do not exist where such protection can be afforded under parens patriae powers or under the court's power to protect the administration of justice, or on the basis explained in *Broadmoor,* or where it is practical for the clinicians (or a representative) to be joined to the proceedings and to assert their own claim.

(8) Notice of an application for such an injunction should be given to media organisations. Notice of the grant of such an injunction, and of any application to vary or discharge such an injunction, should be given to the clinicians affected.

(9) In deciding whether to grant such injunctions at the outset of such proceedings, where the court is being asked to exercise its parens patriae powers, the interests of the child in question, and the need to secure the administration of justice in the proceedings, are likely to justify making an order in circumstances where there is a significant risk that publicity will result in interferences with the child's right to confidentiality and privacy, and in damage to the continued care being provided by the hospital. An order is also likely to be justified under the *Broadmoor* principle, and, where the clinicians (or a representative clinician) are joined, in order to protect the rights of the clinicians.

(10) Such injunctions should be of limited duration. A reasonable duration would be until the end of the proceedings and, in the event that they terminate with the child's death or the grant of the declaration sought, for a subsequent cooling-off period. The length of that period will reflect the court's assessment of the continued risk of interference with the trust's performance of its statutory functions, and in particular with its continuing treatment of other patients, and the time reasonably needed for clinicians to take advice about their personal rights, but is likely to be measured in weeks rather than months or years.

(11) The individuals whose identities are protected by such injunctions should be identifiable by reference to the court's order.

(12) Such injunctions, being contra mundum, should include liberty to any person affected by their terms to apply on notice to vary or discharge any part of the order.

(13) In the event that a fresh injunction (or the continuation of the existing injunction) is sought after the cooling-off period in order to protect the rights of clinicians or other hospital staff, the application should be made by those individuals (or one or more representatives of them), relying on the relevant cause or causes of action. It should be supported by specific evidence.

(14) The court should begin its assessment of any application for such an injunction, or for the continuation of such an injunction, by considering the relevant domestic law.

(15) When the court considers whether the grant or continuation of such an injunction is compatible with the Convention rights protected by article 10, or whether its refusal or discharge would be compatible with article 8, it needs to consider (a) whether there is an interference with the relevant right which is prescribed by the law, (b) whether it pursues a legitimate aim, ie an aim which can be justified with reference to one or more of the matters mentioned in article 10(2)

(or article 8(2), as the case may be), and (c) whether the interference is necessary in a democratic society.

(16) In answering the last of those questions in relation to article 10, the need for any restriction of freedom of expression must be established convincingly. It must be justified by a pressing social need, and must be proportionate to the legitimate aim pursued. This consideration applies with particular force to preventive restraints on publication, and is reflected in section 12(3) and (4) of the Human Rights Act.

(17) In assessing proportionality in a situation where there are competing rights under articles 8 and 10, the court should consider the criteria established in the case law of the European court, so far as relevant.

(18) The court should also consider how long the duration of any restriction on freedom of expression needs to be, and whether the reasons for the restriction may be affected by changes in circumstances. A permanent restriction would require compelling circumstances.

(19) Weight can be given to the importance of protecting the medical and other staff of public hospitals against unfounded accusations and consequent abuse. However, the court should also bear in mind that the treatment of patients in public hospitals is a matter of legitimate public interest, and that the medical and other staff of public hospitals are public figures for the purposes of the Convention, with the consequence that the limits of acceptable criticism are wider than in the case of private individuals.

LORD SALES (CONCURRING)

183. I am in general agreement with the judgment of Lord Reed and Lord Briggs. I write a short judgment of my own to emphasise that it is important to remember that in cases of this sort the clinicians have rights as well, which also require respect and protection. By clinicians I mean the doctors, nurses and medical staff involved in treating a very ill or dying child. The harassment of clinicians which can sometimes occur in these situations was a strong feature of the Charlie Gard case. As Lord Reed and Lord Briggs observe, this appears to be a problem mainly associated with the initial phase of events, when the child is being treated. My comments below are concerned with that phase.

184. In both the Abbasi and the Haastrup cases the present proceedings began in that phase. The applications made by the hospital trusts for injunctive relief were supported by evidence which made it clear that the trusts were principally concerned with the impact

on the clinicians from harassment to which they might be exposed and the trusts maintained that the clinicians' rights, particularly under article 8 of the European Convention, should be protected. In the appeal before us this was all treated as water under the bridge, because the issue we have to resolve concerns the current position in respect of injunctions granted at that earlier stage. Circumstances have changed.

185. However, cases of this sort can arise very suddenly, and hospital trusts and clinicians will naturally look to the decision in this case for guidance as to how they should proceed. I do not think the trusts in the Abbasi and Haastrup cases can be criticised for taking the action they did in the initial phase, nor for taking it upon themselves to assert the rights of the clinicians in their employment. I think they proceeded in a laudable and appropriate manner.

186. As Lord Reed and Lord Briggs point out, there are three sets of interests by reference to which the grant of injunctive relief to protect clinicians might be justified: those of the child (under the court's parens patriae jurisdiction), those of the hospital trust as a body providing a service to the public (*Broadmoor Special Hospital Authority v Robinson* [2000] QB 775) and the personal rights of the clinicians themselves. There may often be an overlap between these interests. But there may not be. For example, in certain circumstances it may be in the best interests of the child to give publicity to their case (say, if it is in their interests to try to raise money via crowdfunding to pay for a very expensive treatment not available on the NHS). In certain circumstances the public service interest of the hospital trust may not cover the rights of an individual clinician (eg if a clinician leaves the employment of the trust part way through the treatment being provided to the child, but remains subject to harassment). So one cannot be sure that the interests of the child and the interests of the trust will serve as an adequate proxy for the interests of clinicians, meaning that the court does not need to consider their rights.

187. Moreover, there is no requirement to go to court in a case involving proposed withdrawal of treatment if there is no dispute about the best interests of the child: see *An NHS Trust v Y* [2018] UKSC 46; [2019] AC 978 a case involving withdrawal of treatment from an adult without capacity where general guidance was given which has been treated as relevant to children in *An NHS Trust v DV (A Child)* [2021] EWHC 1037 (Fam); 180 BMLR 169, para 33, and *R (Bell) v Tavistock and Portman NHS Foundation Trust* [2021] EWCA Civ 1363; [2022] PTSR 544, paras 85-86. Yet the risk of harassment of clinicians may exist in circumstances where there is no such dispute. Quite apart from the views the child's family might have, it has been a feature of some of the cases involving withdrawal of treatment from a very ill or dying child (and as has been seen in other cases involving clinicians, such as in relation to provision of abortion services) that third parties may strongly disapprove of the proposed treatment or withdrawal of treatment and may seek to harass clinicians involved in the individual case or in that and other similar cases. So there may not be occasion to invoke the parens patriae jurisdiction of the court to determine the best interests of the child, and the impact on the child of actions against the

clinicians might be negligible, yet the clinicians might be at risk of being subjected to harassment in breach of their rights.

188. In those cases and more generally it seems strange to say that a claim for an injunction to protect the clinicians' rights could only be justified indirectly by invoking the child's best interests. In my view, it would be appropriate for the court to respond directly to the claim actually brought in such cases, as they did in the Abbasi and the Haastrup cases, namely by identifying the rights of the clinicians themselves and granting relief to protect those rights. In all these cases, the rights of the clinicians have legal significance in the same way as do the rights of the children. A court should not disregard legal rights, wherever they exist and are properly invoked. Also, analytically, since in such cases the impact on the best interests of the child is an indirect consequence of the impact of the harassment on the clinicians, the rights of the clinicians are implicated more directly and are, so to speak, in the front line of the rights requiring protection from the courts rather than in some way a subsidiary matter of concern or irrelevant.

189. In any event, the typical pattern in this sort of situation, as illustrated by both the Abbasi and the Haastrup cases, is that the parents of the child wish to be able to exercise their right to freedom of expression under article 10 of the European Convention in circumstances where that may be in conflict with the clinicians' rights to protection in respect of their private life (or their home, if they are at risk of being subject to picketing and harassment there) under article 8 of the European Convention. Some sort of balance needs to be struck between the competing rights.

190. The concrete implementation of those rights will be mediated primarily through existing legal rights in domestic law, taking account of the state's margin of appreciation. So, for example, where the common law can already be seen to have struck an appropriate balance between the competing rights and interests at stake, within the state's margin of appreciation, there is no need to look back beyond that to the underlying Convention rights, nor is there any justification to disturb that balance by reference to those rights (see P Sales, "Constitutional Values in the Common Law of Obligations" [2024] CLJ 132, 154). Where individual rights are being balanced, the margin of appreciation is usually wide (see *In re JR123* [2025] UKSC 8; [2025] 2 WLR 435, para 54), and this tends to reduce the need or justification for direct reference back to the Convention rights. But the possibility that the common law or statute does not strike an acceptable balance in particular cases cannot be completely discounted, in which case a court as a public authority for the purposes of the Human Rights Act 1998 ("the HRA") (see section 6(3)), subject to a duty to act compatibly with Convention rights (section 6(1)), may be obliged to conduct its own balancing exercise by reference to the Convention rights. In order for a court which has to decide whether to grant an injunction to engage in an assessment in relation to any of these forms of balancing of the competing rights of the parents and the clinicians, it is first necessary that the clinicians' rights have been validly asserted or placed before the court. Otherwise, there is nothing in the scales to be weighed against the rights of the parents and the metaphor of balancing makes no sense.

191. For the purposes of making the relevant balancing assessment, I do not think that the interests of the child or the interests of the hospital trust can serve as a proxy or substitute for the rights of the clinicians themselves. The child has different Convention and domestic law rights of their own, which may sometimes be in conflict with the rights of the clinicians. The hospital trust, as a public authority, unlike the clinicians, does not have relevant Convention rights of its own to be balanced against the Convention rights of the parents. Also, the trust's interests and its domestic law rights are different in character and content from those of the clinicians.

192. Clearly the child, and those acting for them, have no standing to act on behalf of the clinicians to seek to vindicate the clinicians' rights, nor to make submissions on their behalf. The question, arises, however, whether the hospital trust has standing to do these things in the pressurised circumstances of the initial phase.

193. Ordinarily an adult of full capacity who wishes to assert their rights in legal proceedings has the responsibility to do that for him or herself by commencing or participating in legal proceedings. If individuals say they can speak for those in a class of people in the same position, a representation order can be made.

194. However, I do not think it is realistic or fair to the clinicians to expect them to shoulder that responsibility in the initial phase. In that phase the clinicians are concentrating on caring for the child and cannot be expected to have to worry about taking legal advice and protecting their own rights. If their rights are to count for something in that period – and they should – someone needs to be able to act on their behalf to assert their rights by commencing or participating in legal proceedings.

195. In my view, the hospital trust is the obvious appropriate person who can take on that role and act on behalf of the clinicians to assert their rights. This is what the trusts purported to do in the cases before us. I do not think this court should be shy of saying that they acted appropriately in doing so.

196. Two points are relevant here. First, in the pressurised circumstances of the initial phase, the clinicians do not have a fair opportunity to consider, seek legal advice about and take legal proceedings to protect their rights. Their attention is understandably elsewhere, directed to providing care for the child. They should not be distracted from that. It would be completely unreasonable to expect them to have to worry about their own legal position and about taking legal steps to protect themselves and (as may be the case) their families from harassment, assault and so on. If in this phase their Convention rights are to be practical and effective rather than theoretical and illusory, as is required by the Convention (see *Airey v Ireland* (1979-1980) 2 EHRR 305, para 24, and "[t]his is particularly so of the right of access to the courts in view of the prominent place held in a democratic society by the right to a fair trial"), someone has to step in to assert those

rights on their behalf in legal proceedings. The law has to be pragmatic about this. A limited departure from the usual position set out at para 193 above is required.

197. The European Court adopts a pragmatic approach to the question of standing for persons to assert the Convention rights of others where that is necessary to fill a gap in human rights protection: see P van Dijk et al, *Theory and Practice of the European Convention on Human Rights*, 5th ed (2018), pp 64-67; K Reid et al, *A Practitioners' Guide to the European Convention on Human Rights* 7th ed (2023), pp 63-66. The domestic courts are capable of doing the same and should do so in an appropriate case.

198. Secondly, if the court is to receive claims and submissions made on behalf of the clinicians, but not by the clinicians themselves, in the initial phase, it needs to be satisfied that the person doing that is someone who can be taken to be in a good position to assume that role. The hospital trust is the obvious person. It is the body which is responsible for the care being provided to the child and for managing the situation in relation to that. It is in a good position to raise with the court all matters bearing on the fair and appropriate management of the situation in relation to which the court might need to take action and grant relief. Moreover, the trust is usually the employer of the clinicians involved, and so in general terms has responsibility for their welfare in relation to their employment and more specifically owes them a duty of care to provide them with a safe working environment. Where the protection required by the European Convention for an individual's Convention rights is mediated through rights existing in domestic law, the courts should likewise recognise that the trust has standing in the initial phase to act on behalf of the clinicians to assert those rights.

199. I agree that, for good order, the clinicians ought to have been joined as parties at the outset of the proceedings or shortly thereafter in these cases (if necessary, by making a representation order), since in each of them the trust was seeking to assert their rights, any order the court might make in respect of those rights was intended to be determinative and binding as regards the application of those rights, and for that to be achieved in relation to the clinicians they needed to be joined in the proceedings. However, I do not think it was a fatal flaw in the procedure adopted in the heat of the moment at the outset of the proceedings that this was not done. It was a procedural misstep which could be corrected later on, should any problem arise because of it.

200. However, where clinicians are joined as parties to proceedings in this way, it cannot be said that the mere fact of joinder means that their rights are being asserted in the case, still less that they are being asserted effectively. Joinder by itself merely affords the clinicians an opportunity to participate in the proceedings, should they choose to do so, and has the effect that they are bound by any order which is made. But the point made above is that they should not have to worry about being active in asserting their rights in the initial phase. A court will not act to protect the clinicians' rights unless someone with standing to do so asserts that it should and presents submissions to persuade it to act. In

the initial phase, it is the trust who is best placed to do that on behalf of the clinicians while their attention is, for compelling reasons, elsewhere.

201. In order for a person to assert their Convention rights under section 6(1) of the HRA they need to have victim status as that is understood under the European Convention: section 7 of the HRA. In the sort of case we are concerned with, the clinicians do have victim status, so that is not a problem. In the initial phase, the question is whether anyone has standing to act on their behalf to assert their rights as victims. For the reasons given above, in my opinion the courts in the Abbasi and Haastrup cases and in the other cases where the issue of protecting clinicians' rights has arisen have been right to treat the relevant hospital trust as having such standing in the initial phase.

202. Outside the initial phase and a suitable cooling-off period which is long enough to allow clinicians time to collect their thoughts and seek legal advice about their position, the justification for departing from the usual position (para 196 above) disappears and the standard procedural requirement that the clinicians, as adults with capacity, should act on their own behalf is applicable.

203. Lord Reed and Lord Briggs do not rule out the possibility that in some circumstances it will be appropriate for the court to grant injunctions to protect the article 8 rights of clinicians in proceedings commenced by a hospital trust: para 98 above. In my opinion, the initial phase in these cases was in this category.